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ABSTRACT

This handbook has been designed to allow organizations and institutions to develop a basic course in gerontology relative to their own individual needs. Intended to provide a method and a wide variety of materials from which to select in order to design a course suitable for a particular setting, the selection of this format was guided by the need for optional use by a diverse population. The potential learning audience for these materials differs greatly in terms of age, student status, work status, professional interest, and expertise. The settings in which instruction would be provided are also very diverse, including two-year colleges, four-year colleges, professional training programs, inservice training in or relating to community based programs for the elderly, continuing education and extension programs and, possibly, public television. In addition, the instructors delivering the course differ widely in background, training, and teaching experience. Encompassing a far broader range of content and methods than could ordinarily be used by an instructor in a single course or learning sequence, the materials presented are diverse and flexible enough to allow the instructor to select the objectives, content, methods, and resources best suited to his teaching style and the needs and interests of his learning audience. (Author)

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AN INSTRUCTOR'S HANDBOOK FOR THE DEVELOPMENT OF A BASIC COURSE IN GERONTOLOGY

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CHAPTER ONE

INTRODUCTION TO THE HANDBOOK

Reasons for a Handbook Format

This handbook has been dsigned to allow organizations/ institutions to develop a basic course in gerontology relative to their own individual needs. It is intended to provide a method and a wide variety of materials from which an instructor/ trainer/teacher can select in order to design a course suitable for his own setting. In this way, instruction can be individualized for a wide variety of audiences.

The selection of this format was guided by the need for optimal use by a diverse population. The potential learning audience for these materials differs greatly in terms of age, student status, work status, professional interest and expertise. The settings in which instruction would be provided are also very diverse, including two-year colleges, four-year colleges, professional training programs, inservice training in or relating to community based programs for the elderly, continuing education and extension programs and, possibly, public television. In addition, the instructors delivering the course differ widely in background, training and teaching experience.

Due to these dissimilarities, the course materials should be sufficiently extensive, diverse and flexible to allow the instructor to select the objectives, content, methods and resources best suited to his teaching style and the needs and interests of his learning audience. As a result, these materials encompass a far broader range of content and methods than could be ordinarily used by an instructor in a single course or learning sequence. We have avoided designing a course, per se. Instead, we have chosen to provide an orientation and a set of materials, resources, and strategies that would enable a particular instructor to design and implement a more effective core course in gerontology.

Two basic assumptions guided the development of the materials in this handbook. First, it was assumed that the learning audience would share a minimum eleventh grade competency in reading and writing skills, but little or no previous formal training or knowledge in gerontology. (A more detailed discussion of potential learning audiences appears in a later section.) Second, it was assumed that these materials would be utilized in learning programs encompassing no less than thirty total hours of study and/or instruction. The upper limit is more difficult to define, but we have assumed an approximate maximum of 150 total hours of instruction and/or study.

CHAPTER ONE

In designing teaching strategies, relatively non-traditional methods (such as role playing, field learning, use of media, etc.) are emphasized. The intent was not to substitute or replace traditional methods of instruction with non-traditional methods. Instead, we assumed that potential instructors have the knowledge and skills needed to prepare lectures, lead discussions, and assign library research papers. Instructors are less likely to be familiar with non-traditional methods that are effective in teaching gerontological knowledge, skills, and attitudes. Thus, we have recommended such strategies as a compliment to the existing styles and capabilities of the instructors.

The basic course to be designed will draw on a wide variety of appropriate disciplines selected to adequately represent the core knowledge available in gerontology and geriatrics. It will attempt to analyze the changing biological, psychological and social characteristics and needs of older people as they interact with the age-related social, economic and political influences of American society. Implications for social policies and intervention strategies are explored.

These materials should contribute to a view of the aging process and the aged population equally balanced between knowledge and attitudes. That is, the course material should result in an objective awareness of both the benefits and liabilities of growing old. For example, this course would illustrate that gradual deterioration of perception, mobility, health and income tends to accompany increasing age. At the same time it should be clear that these changes are very gradual and often imperceptible for many older persons. In fact, these changes are often compensated by increasing experience and efficiency, so that the great majority of older persons are not significantly impaired by these changes.

These materials should be effective in working towards a broad range of learning objectives, including: 1) affective objectives (pertaining to attitudes, values and feelings); 2) cognitive objectives (pertaining to knowledge and understanding); and, 3) behavioral objectives (pertaining to skills).

The three domains of objectives are listed in approximate order of their perceived importance in the development of these materials. That is, affective objectives are given primary emphasis since attitudes often determine working effectiveness. Cognitive objectives must receive a nearly equal emphasis since a sound knowledge base is a prime prerequisite for effective intervention or further study in gerontology. Skill objectives are weighted the least.

A listing of possible overall objectives for this learning program follows in a later section. In addition, each content unit includes a listing of objectives specific to that unit.

Range of Possible Students for the Course

Responding effectively to the learning styles and educational needs of a diverse audience represents a serious challenge to the teacher and instructional designer. No set of materials can reasonably encompass all possible styles and needs. We have attempted, however, to provide for the range of styles and needs that exist in learning audiences. This would include:

A. Entry level practitioners, aides, and paraprofessionals in geriatric facilities or community programs for the elderly.

B. Adult volunteers in any of the above programs.

C. Students or interns in professional training programs, such as nursing, social services, nutrition, recreation, occupational therapy, physical therapy, adult education, rehabilitation counseling, law, information sciences, communications therapy, long-term care administration, etc.

D. Practicing professionals in any of the above disciplines seeking specialized continuing education.

E. Students in undergraduate or early graduate phases of pursuing long-term teaching/research careers in an academic discipline, such as sociology, psychology, political science, human development, etc., with a special interest in gerontology.

Potential audiences could encompass all of the above and others. The authors of these materials, however, have chosen to emphasize needs of audiences at the lower educational levels listed above. Thus, these materials are best suited to groups A, B, and C, but might also be appropriate to the others.

Suggested Overall Course Objectives

Objectives, as the term is used in this handbook, relates to the goals the instructor wants his students to attain. These goals, as outlined below, fall into three areas: goals related to knowing (cognitive objectives); goals related to feeling (affective objectives); and goals related to doing (behavioral objectives). The list of overall course objectives has deliberately been made extensive to allow the instructor

a comprehensive overview of appropriate goals. From these goals, the instructor may select those which are appropriate to the specific audience for whom he is designing the course and may discard those which are not appropriate.

In addition to these overall objectives, each content unit of the course outline suggests goals or objectives specific to the unit.

A. Affective objectives - the domain of motives, values, attitudes and feelings.

The student of these course materials should develop:

1. An awareness and appreciation of his own aging process and its implications for his personal future.
2. An involvement in resolving his own age-related stereotypes, prejudices, fears, hostilities, anxieties and/or denial.
3. An awareness of his (and others) culturally based views of aging and older persons.
4. A desire to engage in further contact with, study of, and/or services to older persons.
5. A sense of empathy with the older person's strivings to maintain a sense of identity and competence in the fact of accelerating changes in his internal and external environments.
6. An understanding of the impact of advanced age on the older person's perspectives regarding his personal past and future.
7. A sense of curiosity, interest, and commitment to older persons and a sense of commitment, advocacy, and leadership in his work with the aged.
8. An awareness of the relationship among age linked attitudes and basic cultural values concerning, e.g., old/new, modern/traditional.
9. A respect for the aged as valuable human resources, reflecting the experience and wisdom that they can offer to themselves, others and society.
10. An appreciation and respect for the fundamental unity and continuity of the human life cycle, including a positive awareness of issues relating to mortality and death.

11. A commitment to and appreciation of basic gerontological research and theory, as tools in lending insight to the aging process and the experience of older persons.

12. An appreciation of the great diversity that exists among older persons and a binding respect for each older individual as a unique human being unlike any other member of his own or different age groups.

13. An appreciation for the linkages among and contributions of a variety of disciplines and professions related to gerontology.

14. An appreciation for the complexity of the forces that shape the older person's experience and circumstances.

15. A hesitancy in formulating simplistic problems-analysis and problem-solving approaches to gerontological issues.

B. Cognitive objectives - the domain of knowing and understanding.

The student of these course materials should:

1. Demonstrate a factual knowledge of the distribution of basic demographic characteristics among older populations around the world and in New York State including age, sex, marital status, health status, residential arrangements, income, compensation patterns, geographic distribution, ethnicity, and friendship patterns.

2. Enumerate the major data sources, such as periodicals, in the field of gerontology.

3. Enumerate, by name and purpose, the principal local, regional, and national agencies and associations that serve the interest of gerontology and older persons.

4. Identify the tenets, strengths, and weaknesses, of the major theories of the aging process.

5. Identify and describe the major age-related changes in biological, psychological and social functioning.

6. Identify, describe, and evaluate the principal methods of gerontological research.

7. Describe actual and potential roles and role changes available to persons in later years of the life cycle.
8. Assess the impact of economics, social forces, cultural value systems, and social institutions on the needs and characteristics of the elderly.
9. Describe the personality characteristics and life style components associated with adjustment to old age.
10. Identify and describe the impact of critical stages and events in later portions of the life span including menopause, major illnesses, widowhood, retirement relocation and impending death.
11. Describe major variations in the characteristics, needs, and resources of ethnic, cultural and geographic subpopulations of the elderly.
12. Describe major historical trends in gerontology including level of social awareness, longevity, demography, social intergration of the elderly, and research activities.
13. Identify major societal stereotypes of the elderly and ways of dealing with them.
14. Identify and understand principal issues in attitudes toward death among the elderly and characteristics of quality terminal care.
15. Describe the influence of major disease processes on functional capacities of the elderly.
16. Describe and understand the nature and causes of intergenerational conflicts that exist between the elderly and the young.

C. Behavioral objectives - the domain of skills.

The student of these course materials should be provided with basic tools from which he/she can develop:

1. An ability to establish effective communication with persons suffering impairments of cognition perception, and/or speech.
2. An ability to respond with interest and sincerity to the variety of interests and concerns that an older person may bring to an interpersonal situation.
3. An ability to find and utilize basic literature in gerontology.

4. An ability to obtain relevant local, regional, or national data on gerontological problems of interest to the student, practitioner, and researcher.
5. An ability to compile raw data (as above) and use data effectively in the analysis of cause-effect and/or the formulation of effective intervention strategies.
6. An ability to advocate more effectively for the needs of older persons.
7. A beginning ability to formulate appropriate matchings between the complex needs of older persons and suitable needs - meeting environments and programs.

CHAPTER TWO

USING THE HANDBOOK

This chapter has been written to give you, the instructor, some guidelines for designing your instruction. Begin by familiarizing yourself with the contents of this handbook. Then use the suggestions in this chapter to outline the information you want to include.

There are six basic questions to answer when using this guide to design instruction. These questions are:

1. What information does the handbook provide?
2. Who will you teach?
3. What do your students need to know?
4. What do you have available?
5. How can you best teach them?
6. How will you know they have learned?

In the following discussion, we have tried to provide you with some tools for answering these questions.

1. What information does the handbook provide? - Becoming familiar with the materials.

It is time to familiarize yourself with the information in Chapter Three. As you read through the content areas, bear in mind the kind of students for whom you are designing the course. The following questions may provide a useful framework for reviewing the content chapter.

1) What is your own expertise?
2) With what content are you comfortable? Uncomfortable?
3) Do you understand the content from the text portions of the unit or will you need to do further reading?
4) What content in this guide is appropriate to your students? Inappropriate?
5) For what content might you require outside help in teaching?

For example, if you were designing instruction for volunteers in a senior citizens centers certain materials may be less useful than they might be for nurses aides in a geriatric facility. Although the chapters in this guide provide an overall introduction to gerontology, and should all

be represented in your instruction, the depth and amount of material covered in each section should depend on the needs of your students.

2. Who will you teach? Defining the audience.

The next step in designing this instruction is to determine who you are to teach. By understanding your audience and their needs, you can provide instruction that will be most meaningful and relevant. Perhaps you are working with students whose needs are well known to you. If you have taught this group before, you may already have enough information about them to proceed with designing the course.

If you are not familiar with your group of students and their particular needs, you may want to gather some information. The following questions may provide facts about your audience useful in course design. You may wish to add questions of your own.

1) Who are the students? How many are there?
2) What is their reading level? Their educational background?
3) Why are they taking the course?
4) What attitudes toward the aged do you want to develop?
5) What do they already know about gerontology?
6) Do they work directly with older persons?
7) Are the persons they work with sick or well?
8) What is the setting in which they work?

If there is sufficient time, you may want to select some of these questions to include in a questionnaire for your prospective students. The answers should be considered in selecting the appropriate content and instructional strategies, or for use in revising the course.

For example, from the results of your questionnaire you might learn that your students are volunteers in a senior citizens center. Most have a high school education and know little about the field of gerontology. They are taking the course because they deal directly with healthy older people and are interested in working more effectively. This information can help you in determining what and how much information they will need.

3. What do your students need to know? Selecting goals and objectives.

In addition to the overall course objectives listed in the first chapter, each unit has suggested goals or objectives relevant to the content. You must now determine which objectives are appropriate to your particular students and setting. One way of deciding this is to rank order the lists of objectives.

Begin with the overall course objectives in Chapter One. Ask yourself:

1) What is it my students need to know?
2) How do I want them to be different when they have completed my course?
3) What attitudes should they develop?
4) What factual knowledge do they need?
5) What skills must they learn?

Part of deciding what they need to know is determining what they already know. You may want to design a test to be given at the beginning of the course. This can tell you what information they already have. This will keep you from covering unnecessary content.

Now list the objectives in order by how useful they are and how well they apply to your students. Cross off those that seem inappropriate to your students. Add ones that seem to be missing.

This process should then be repeated for each content unit. You will now have a list of goals specific to your own students, setting and concerns.

4. What do you have available? Defining resources and constraints.

Besides knowing your students, you need some information on the setting in which your course will be offered. You must know what resources are available for your use. Resources may include people, materials, equipment and facilities.

You must also know what limitations are placed on course delivery. In addition to limited resources, constraints can be based on institutional requirements such as time and credit structure.

Questions that might be helpful in defining resources and constraints are listed below.

1) What room will you teach in? How large?

2) What equipment is available?

3) Is there a library for your students to use?

4) Can you order materials, books, and other teaching units?

5) Will you teach the course alone or can you enlist the aid of subject area specialists?

6) How long will you have to teach the course?

7) What does the institution hope to achieve by sponsoring this course?

8) Is the course for credit or is it non-credit?

Obviously, this list is not all inclusive. Add any other resources or constraints that you need to consider. This will help you design a course that you can realistically deliver.

If you are trying to instruct aides in a nursing home, you may not have a library available. You must then consider where you can get the materials you need and how to make them available to your students. In addition, if you are instructing full-time workers, there may be scheduling problems. Such as, what time to meet and how many sessions to hold. Finally, if the students are receiving credits or certificates for the course, you may have to specify requirements.

5. How can you best teach them? Selecting instructional strategies.

Now that you have decided upon the objectives and content for your course, it is time to consider how to best teach your students. The effectiveness and efficiency of the course (for both the instructor and the student) can be increased by the use of an appropriate strategy.

It is not always clear or easy to choose what teaching methods to use. Constraints and available resources play a large role in the decision. However, listed below are a few guidelines to aid you in selecting instructional methods.

1) Begin with a statement of each of your objectives.

2) Consider the needs of your students as you have defined them.

3) Ask yourself what things they should know and what they should be able to do at the end of instruction.

4) Determine whether your objective falls into the cognitive, affective, or behavior category. (These are defined in Chapter One.) This may help you decide upon an appropriate activity.

5) Use this information to decide on the best way to teach. (See the list of suggested strategies and resources below.)

6) If possible, test the strategy on a small number of students. You will discover that some of your best planning doesn't always bring about the results you anticipated.

7) Be prepared to reconsider some of the strategies you thought would work, substitute other strategies and readjust.

A number of content units in this handbook already suggest possible methods that you might consider using. However, if there are no suggestions, or if they are not appropriate, you might select from the list below. In considering instructional materials and activities, you should look for prepared materials that are available and fit your needs.

A note of caution: Since some of the suggested strategies listed deal with forming or changing attitudes they should only be used by an experienced instructor. If you select a strategy such as role playing or games and simulations, you will need to invite a guest instructor who has led such activities before.

Possible Instructional Strategies:

1) Dramatized presentation, followed by questions.
   a) Live (demonstration, skit, etc.)
   b) Audio-visual reproduction (tv, films, slide-tape sequence).
2) Guided discussion.
3) Laboratory experiences.
4) Computer - assisted instruction.
5) Field trips.
6) Role playing.
7) Tutoring.
8) Recitation and drill activities.
9) Games and simulations.
10) Verbal explanations/lectures (with or without visuals)
11) Projects.

Resources

1) Objects that support strategies (e.g., models, samples)

2) Still pictures (slides-35mm, filmstrips, overhead transparencies, charts, maps and posters).

3) Motion pictures (16mm films, single concept 8mm films, locally produced motion pictures).

4) Teacher, outside resource people, other students.

5) Audio tapes and records, radio programs.

6) Books, texts and reference books, workbooks, and programmed instruction, periodicals, handouts.

6. How will you know they have learned? Determining evaluation strategies.

Evaluation is the process of gathering information in order to make a decision. There are basically two kinds of evaluation questions to consider for this course.

1) How well have you taught?

2) How well have they learned?

How well have you taught? - There are two reasons for asking this question. First, as the instructor, you should learn how the course meets student needs. From this information, decisions on the effectiveness of the course and the appropriateness of the objectives can be made. The second reason relates to the decision that the course isn't as successful as anticipated. You will then need to go back through the process described in this chapter in order to discover where the problems are.

How well have they learned? - Students may be taking this course for credit or non-credit. If there are to be credits, grades or certificates awarded when the course ends, you will need to develop some means of judging student performance. These tests are the kinds you associate with formal schooling.

If the course is non-credit, you may choose not to test at all. Or, you may test in the traditional manner so both you and the student can tell how much they know.

CHAPTER THREE

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Unit Seven: Effective Intervention with the Aged
Unit Eight: Public Policy and the Aged

INTRODUCTORY UNIT

The sections in this unit are intended to provide an introduction to the course you are designing for your students. The purpose of beginning your course with such an introductory unit is four-fold. First, you need to develop motivation on the part of the student for attending to the content of the course. In the introductory unit you might want to explain why the topic of aging is important, both in general and personally. Second, the introductory unit can provide an overview of the course as you have designed it. Third, it can establish a framework for major concepts and principles that tie together the individual topics and disciplines from which the basic course is constructed. Finally, it can help to develop appropriate feelings and attitudes about older people and about the reality of one's own future and aging process.

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I. Why Study Aging and the Aged?

A. Introduction

The student may enter this course of study with various combinations of naivete, indifference, and/or anxiety. The first issue facing the instructor will be to develop an interest in the subject matter on the part of the student. The student should develop an understanding of the importance and relevance of this material as early as possible. The instructor should clarify and dramatize the impact of aging on individuals and society and make it clear that further study will be of interest and importance to the student. Disinterest, apathy, and/or anxiety concerning aging among the students should be dealt with at the very beginning of the course before proceeding to the major content areas. During these first units then, the instructor should, perhaps, present relatively little content but should attend closely to instructional methods and materials that will enhance the students' motives and prepare a foundation of positive attitudes for the remainder of the course.

B. Basic Objectives of this Unit

1. To identify major social and personal issues relating to the phenomenon of growing old and the disciplines of gerontology and geriatrics - to develop an awareness of the reasons for studying gerontology.

2. To develop the students' interest, desire, and readiness for the study of gerontology.

C. Specific Topics and Issues

1. The universality of aging - occurring in all species and faced by all individuals (at least all who escape the only alternative - an early death).

2. Definition and discussion of the concept "Aging," which involves the systematic, cumulative, irreversible changes that occur in all living species during the course of their life cycles.

3. Past and future growth of the aging population, both numerically and proportionately. Today, one of every ten Americans is beyond the age of 65 - approximately 20 million older persons. (Only 4% of the population was over 65 in 1900 - this may reach 11-13% by the year 2000).

INTRODUCTORY UNIT

4. Social problem aspects of aging and implications for social policy - present and future (briefly): The combination of greater longevity (more persons reaching a period of old age) and early retirement will mean that fewer and fewer adults will be wage earners, while more and more adults will be demanding more of the nation's human service systems, such as health care, economic support, specialized housing and transportation. Relations among the generations are likely to experience new changes and strains.

5. An historical view of aging and gerontology:

   a. Increased life expectancy, primarily due to declines in infant mortality.

   b. Early theories of aging, e.g., "fountain of youth," hormone injections, glandular transplants.

   c. Early gerontological research was scarce and largely biomedical, with very little emphasis on behavioral and social aspects of aging.

   d. Legislation (major examples):

      1) Social Security Act,

      2) White House Conferences on Aging (1961 & 1971),

      3) Older Americans Act and amendments which provided federal emphasis and financial support for concerns of older persons.

   e. Gerontological Society, American Geriatrics Society, and American Association of Retired Persons - discuss dates of founding, areas of emphasis, growth of membership, current purposes.

6. Definition and discussion of the concepts "Gerontology" (the science and study of aging processes) and "Geriatrics" (the branches within the human services professions that specialize in services to older persons).

7. The current status of gerontology - a summary:

   a. Legislation and funding support (greatly expanded, compared with two decades ago).

   b. Organizations and agencies (generally proliferating and specializing).

c. Research (expanding and becoming more sophisticated).

d. Education and training (showing considerable growth and specialization).

8. A glimpse at the future of aging (discuss the growth in the size and needs of the older population, and the impact on social policy, economics, and human services).

D. Suggested Instructional Methods

(Topics # 1 and 2)

1. Lecture and discussion - encourage students to examine and exchange their own feelings about growing old.

2. Ask each student to draw a picture of him/her self as might be seen at age 70. Students describe and discuss their pictures.

3. Form pairs of students - each student "interviews" the other concerning feelings about aging, expectations concerning his/her own future aging process, meanings of aging, etc. - instructor should provide broad interview guides.

(All remaining topics, # 3 - 8)

4. Lecture, with the aid of transparencies and/or handouts of graphs and tables of basic demographic trends and projections.

5. Brief pre- and post- tests of major points would help consolidate the learning.

6. Didactic - pose possible problems and situations; illustrate trends; discuss implications.

E. Bibliography

All of the sources are basic gerontology texts, which provide brief introductory chapters well-suited to content and objectives dealt with in this first unit.

Atchley, Robert C. The Social Forces in Later Life. Belmont, California: Wadsworth, 1972, Chapter 1.

INTRODUCTORY UNIT

Boyd, Rosamonde R. and Oakes, Charles G. Foundations of Practical Gerontology, 2nd edition. Columbia, South Carolina: University of South Carolina Press, 1973, Chapters 1 and 2.

Curtin, Sharon R. Nobody Ever Died of Old Age. Boston: Little, Brown and Co., Chapters 1, 2, and 12.

Geist, Harold. The Psychological Aspects of the Aging Process. St. Louis: Warren H. Green, Inc., 1968, Chapter 1.

Manney, James D., Jr. Aging in American Society. Ann Arbor: Institute of Gerontology, 1975, Chapter 1.

II. Portraits of Aging Individuals

A. Introduction

In addition to the student's need for basic knowledge and skills pertaining to gerontology, the student should develop an early sensitivity to older persons themselves. This should include an appreciation of individual differences and a sense of the range of concerns, interests, needs and life styles as presented and expressed by actual older persons. This process should also contribute to an appreciation of the vitality and competence displayed by older persons. This is, perhaps, best accomplished by providing students with opportunities to see and hear older persons speak for themselves.

B. Basic Objectives of this Unit

1. An involvement in resolving his own age related stereotypes, prejudices, fears, hostilities, anxieties and/or denial.

2. A desire to engage in further contact with, study of, and/or services to older persons.

3. A sense of empathy with the older person's strivings to maintain a sense of identity and competence in the face of accelerating changes in his internal and external environments.

4. A sense of curiosity, interest, and commitment to older persons and the field of gerontology, and a sense of commitment, advocacy, and leadership in his work with the aged.

5. A respect for the aged as valuable human resources, reflecting the experience and wisdom that they can offer to themselves, others, and society.

6. An appreciation of the great diversity that exists among older persons and an abiding respect for each older individual as a unique human, unlike any other member of his own or different age groups.

7. An ability to respond with interest and sincerity to the variety of interests and concerns that an older person may bring to an interpersonal situation (basic competence).

8. Identification and description of the impact of critical stages and events in later portions of the life span including menopause, major illnesses, widowhood, retirement, relocation and impending death (beginning awareness).

9. An understanding of the impact of advanced age on the older person's perspectives regarding his personal past and future.

C. Specific Topics and Issues

The following topics can be discussed with older persons and/or shared among class members following films or readings. The emphasis in this unit should be on experiences and attitudes. Relevent theory and data will be provided in later units of the course.

1. Age, place of birth, brief life history (family, vocation, avocations, etc.)

2. Living arrangements: past, present, future; residential preferences.

3. Impact of retirement; satisfaction with retirement.

4. Family and social relations: marital status, children, relations with siblings and other relatives, neighbors, confidants.

5. Activity patterns and use of personal time:

   a. Hobbies, travel, etc.

   b. Organizations: memberships and participation patterns.

6. Income: level and source, adequacy, use of, changes since retirement.

7. Health - past and present; use of health services.

8. Changes (personal, social, cultural, etc.)) experienced during past 20 years.

9. Expectations concerning the future: both general and personal.

10. Sources of satisfaction and problems.

D. Suggested Instructional Methods

Students should be encouraged to see, hear, and/or read personalized accounts of experiences of older persons, in their own words. The following suggestions might be used as alternatives or in combination.

1. Reading, analysis and discussion of printed case studies.

2. Commercial media (films, videotapes).

3. Panel of elderly persons invited to visit the class, describe their experiences, and answer questions.

4. Interviews of selected older persons.

   a. By instructor or others

      1) Audio-taped

      2) Video-taped

      3) Slide/tape combination

      4) Conducted "live" during class session

   b. Each student interviews an older person, utilizing an "inverview guide" provided by the instructor. These experiences can be described and discussed in class by the students.

E. Bibliography

Curtin, Sharon R. Nobody Ever Died of Old Age. Boston: Little, Brown and Co., Chapters 3 - 11. (a warm, lively, journalistic portrayal of older persons living in diverse circumstances, and an indictment of our society in neglect and abuse of the elderly).

Kimmel, Douglas C. Adulthood and Aging. New York: John Wiley and Sons, 1974, pp. 332-342, 391-402. (includes a series of three brief case examples of actual older persons living "competent and varied lives in the real world").

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III. The Aging Population (demography: United States and New York State elderly)

A. Introduction

This unit is intended to provide basic data essential for understanding the size of the older population as well as the numerical and proportional distribution of demographic characteristics. The basic intent here is to provide a sense of the "whole" - an overview of the basic needs and characteristics of the aging populations of New York State, the United States and, if possible, local communities and regions. The recommended approach is factual, but implications and examples should be explored throughout. Individual differences can be emphasized by distinguishing among specific subgroups of aged, such as male/female, urban/rural, minorities, etc.

B. Basic Objectives of this Unit

The student should:

1. Demonstrate a factual knowledge of the distribution of basic demographic characteristics among older populations around the world and in New York State including age, sex, marital status, health status, residential status.

2. Describe major variations in the characteristics, needs, and resources of ethnic, cultural and geographic subpopulations of the elderly.

C. Specific Topics and Issues (Data should be provided on the United States as a whole, as well as New York State. If available, data on the local county and community should also be examined.)

1. Numerical and proportional distributions of elderly, according to:

   a. Age (e.g., 65-74, 75-84, 85+).

   b. Sex (note the growing over-representation of females with increasing age).

   c. Marital status (note that most elderly males are married, most elderly females are widowed).

   d. Ethnicity

2. Geographic distributions of older persons by states and regions. Also, describe urban/urban fringe/rural distributions.

3. Income levels and sources, according to:

   a. Sex.

   b. Marital status (note the economic disadvantage of older persons without spouses).

   c. Ethnicity (minorities are particularly disadvantaged economically in old age).

4. Marital and family status - explore the distances and frequency of contact between family members:

   a. Spouse.

   b. Living children.

   c. Living parents.

   d. Siblings.

5. Living arrangements:

   a. Alone/with others.

   b. Owned/rental dwelling.

   c. Single family/multiple family/congregate/institutional.

6. Special vulnerable groups of the aged:

   a. Economically disadvantaged.

   b. Institutionalized.

   c. Widowed, Divorced, Never Married.

   d. Racial and ethnic minorities.

   e. Physically handicapped.

   f. Physically and socially isolated.

   g. Chronically ill.

D. Suggested Instructional Methods

All of the above topics lend themselves to a didactic approach, which should be supplemented by all of the following, if possible:

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1. A pre- and post- test, written or oral.

2. Printed material for distribution: graphs, tables, summaries of statistical information.

3. Lecture, with transparencies of graphs and tables.

4. Discussion of examples and implications of the data.

E. Bibliography

The following textbooks provide useful and comprehensive summaries of national data on the elderly:

Atchley, Robert C. The Social Forces in Later Life. Belmont, California: Wadsworth, 1972, Chapters 7-9.

Botwinick, Jack. Aging and Behavior. New York: Springer, 1973, Chapter 1.

The most comprehensive and useful source of data for this unit is:

Riley, Matilda W. and Foner, Anne. Aging and Society, (Vol. 1: "An Inventory of Research Findings"). New York: Russell Sage, 1968, Chapter 2.

Your nearest "Area Commission on the Aging" and State Office for the Aging may be helpful in obtaining relevant state and regional data on older persons in your area.

IV. Principles and Concepts in the Study of Aging

A. Introduction

Throughout this course, the student will be exposed to a great deal of raw information. The student may need a conceptual framework and a set of principles around which he can organize his information and experience and achieve applicability to the realities of older persons. In addition, the student should be sensitive to his own (and others') fears, preconceptions, stereotypes and myths pertaining to older persons. These issues, and the related feelings, should be explored intensively and early.

B. Basic Objectives of this Unit

1. An awareness and appreciation of his own aging process and its implications for the learner's personal future.

2. An awareness of his (and others) culturally based views of aging and older persons.

3. An awareness of the relationship among age-linked attitudes and basic cultural values concerning, e.g., old/new, modern/traditional.

4. An appreciation and respect for the fundamental unity and continuity of the human life cycle, including a positive awareness of issues relating to mortality and death.

C. Specific Topics and Issues

1. Aging as a developmental process that begins at conception and is orderly, sequential, cumulative, and irreversible. The continuities of the life cycle should be explored and emphasized.

2. Examine the stereotype "Senescence is a 'disease' that strikes in late life."

3. Define and discuss the concepts "Senescence," "Development," "Chronological Age," "Developmental Age."

4. Social Change, Social Values, and their impact on aging and our views of the aged.

   The implications of the following issues might be explored:

a. The strongly positive values we place on: 'progress', 'change', 'new', 'youth', 'technology', 'the future', 'productivity', 'independence', 'materialism'.

b. The accelerating pace of soical and technological change and its impact on intergenerational relations.

5. Define and discuss the concepts "Old/Aged/Elderly."

6. Examine the stereotype "Older people are passive, rigid and/or negativistic."

7. Basic human needs and their importance in understanding behaviors of aged and non-aged. It would seem that basic human needs are similar throughout the life cycle, but we often overlook the "higher-order" needs of older persons. Maslow's hierarchical scheme is helpful here:

   a. Basic needs:

      1) Physiological needs

      2) Security needs

   b. Higher-order needs:

      1) Love and belongingness needs

      2) Esteem needs

      3) Self-actualization needs

8. Resources for gratifying basic human needs and their differential availability to you and aged:

   People draw upon a variety of resources in seeking gratification of their needs. At different ages, however, certain resources are more abundantly available than others. Each of the resources listed below might be considered as an aid in obtaining need gratification. Discuss the relative availability of each resource to various age groups.

   a. Income, a major problem for many elderly.

   b. Health, a resource for most young persons.

   c. Time, a major resource for many elderly - sometimes too much of a good thing.

d. Friends and relatives - a major resource for many elderly, not available to some others.

e. Involvement in society - often denied, through lack of meaningful roles, inadequate income and transportation.

f. Training, experience and knowledge - a major resource of our elderly, seldom used to best advantage by society and the young.

g. Intelligence and special aptitudes - a major resource of our elderly, seldom used to best advantage by society and the young.

9. Examine the stereotype "Older people cannot learn new skills or change old habits - 'you can't teach an old dog new tricks'."

10. Define and discuss the concept "Senility" - what is it, in behavioral terms" What proportion of older persons are affected? Discuss the variety of possible causes.

11. Independence vs. Dependence - changes in/during the life cycle; the importance of pride and self-sufficiency to everyone, including the elderly.

12. Examine the stereotype "Older persons are like children - 'silly, dependent, cute, and troublesome'."

13. Individual differences are at least as extensive among the elderly as among youth, resulting from the cumulative effects of a long life of unique and differentiating experiences. As a result, each older person is unique. It is essential that this principle is appreciated early in this course, for there will be a strong tendency to generalize throughout the succeeding sessions. One should continually guard against discussing "older persons", "the elderly", "senior citizens", "them", as a homogeneous group.

14. Examine the stereotype "Most older persons are basically alike, and fundamentally different (as a group) from most younger persons."

D. Suggested Instructional Methods

This instruction should be highly interactive, with many opportunities to examine, share, and challenge attitudes and feelings. A lively discussion is to be encouraged. In addition, the following strategies might be helpful.

1. A pre- and post- test on definitions and stereotypes.

2. Students conduct brief interviews with friends, neighbors, family members, or "persons on the street" concerning stereotypes.

3. Collect cartoons about older persons - examine and define the stereotypes which they reflect. How are older persons portrayed in cartoons? Some common examples include:

   a. Portrayals of older persons as feeble, doddering, prune-like, stooped.

   b. The "dirty old man" image.

   c. Older women (as mothers-in law, grandmothers, and mothers) interfering with younger family members and imposing rigid, moralistic, outdated methods and standards.

   d. Older persons as rigid, and conservatively critical of contemporary society.

E. Bibliography

Bengston, Vern L. The Social Psychology of Aging. New York: Bobbs-Merrill, 1973, Chapters 1 and 4. (A brief book that explores the processes of aging in the context of the social system and the impact of culture on aging via age grading, age-related roles and norms, and the normlessness of old age.)

Kimmel, Douglas C. Adulthood and Aging. New York: John Wiley and Sons, 1974, Chapter 1. (Provides a developmental perspective on aging with an emphasis on cumulative genetic and environmental interactions and the underlying continuity of the life cycle.)

V. The Data Base of Gerontology

A. Introduction

Before proceeding to the major content units of the course, students should develop a basic awareness of the nature and limitations of the research data that they will be using. Readings and lecture materials will make frequent references to research. These references may seem confusing or irrelevant at times. In other cases, the research may seem to offer (too) simple conclusions or recommendations. Students may be "afraid" of research and statistics or may feel that it is a waste of their time and the government's money. We recommend that the instructor deal with these attitudes early - not by offering a short course on research methods, but rather by exploring the value of research and some of the special issues and problems that arise in gerontological research.

B. Basic Objectives of this Unit

1. To become a more effective consumer of research, with a beginning ability to critically evaluate the appropriateness of conclusions drawn from gerontological research.

2. To better understand the limitations of the research that one reads (e.g., for this course).

3. To appreciate some of the ways in which gerontological research can be of value to geriatric practice and the development of social policy - to understand the relative advantages/limitations of systematic data-gathering as opposed to personal experience.

4. To demonstrate a basic understanding of data sources and their limitations.

5. To appreciate why some seemingly irrelevant research situations (e.g., gerontological research on rats, mice, drosophila, primitive cultures, etc.) may provide meaningful perspectives on causative factors in human aging.

C. Specific Topics and Issues

1. Gerontology is a relatively new discipline, with a brief scientific tradition. As a result - many basic research problems are as yet unresolved, including:

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a. The Measurement of Age - related phenomena: some unique measurement problems exist in gerontology. For example:

1) Researchers often rely on instruments that were developed for use with younger subjects (e.g., measures of intelligence and personality). The appropriateness of such applications should be examined. Specialized instruments for use with the elderly are scarce.

2) Most standardized measures do not include performance norms for the elderly. Thus, elderly subjects are often unfairly compared with the performance of younger persons. This can be particularly problematic in clinical settings (e.g., audiometry results, fluid electrolyte balance, kidney functioning, dietary intake, etc.).

3) The research is more likely to encounter communication impairments (impaired speech, vision or hearing) and/or non-English speaking subject in an elderly sample.

b. Sampling Problems:

1) Most elderly are not conveniently available for research, compared with school-age children and college students. Researchers have often (and sometimes inappropriately) turned to "captive audience" in institutions and have obtained unrepresentative results - generalizations to broader populations of elderly must be examined carefully.

2) Elderly may be distrustful of young interviewers and/or of research itself. They may question the integrity of the researcher or the value of participation.

3) Many elderly are geographically and/or socially isolated. Truly representative samples are difficult to obtain.

4) For a variety of reasons (see below), longitudinal studies are often necessary, in which the same persons are contacted two or more times before and after a specified time interval. As death rates increase with age, longitudinal samples of elderly become smaller and less representative over time.

c. Biases in Gerontological Research

Gerontologists (and others) have long assumed that aging is a process of decline and have sought to identify and measure age-related declines. There is much research on senescence, but little on the positive aspects of aging - i.e., what improvements are associated with aging? Too often, the narrow scope of gerontological research has reflected the society's stereotypes concerning the aging. Too often, perhaps, we have not asked imaginative and/or value-free research questions.

d. The Predominant Role of Values in Gerontological Research

A prevailing concern for the well-being of older persons has been, perhaps, the major stimulus for the growth of the field of gerontology. This concern for older persons, however, creates problems for the researcher who seeks to answer important questions while maintaining his/her objectivity. We cannot, of course, abandon our exploration of relevant questions, but the researcher and the student must constantly search out the impact of the researchers, hopes, concerns and commitments on the data and the resulting interpretations.

2. Special Problems in Assessing Change and Causation in Gerontological Research:

A major focus of basic gerontological research is the determination of the rate, direction and magnitude of change which occurs in the performance and characteristics of human adults over relatively long time intervals. Unfortunately, human researchers must face the same life expectancies as their human subjects, making this pursuit a most difficult and frustrating one. To complicate matters, once one has identified a bona fide age-related change, the next question we must face is "What caused the change"?

A discussion of research problems related to change and causation is beyond the scope of this course. Some attention should be given, however, to the basic strategies employed by gerontologists in pursuit of these answers. They include:

a. Cross-sectional designs - in which the performance and/or characteristics of samples of different ages are compared. This strategy enjoys the advantages of time and cost, but is a relatively weak tool in determining causation.

b. Longitudinal designs - in which one or more samples are studied at repeated intervals. Enables one to study change more precisely, but is more costly, time-consuming, and only slightly more definitive in determining causation.

c. Cross-sequential designs - in which cross-sectional and longitudinal approaches are combined. Costly, complex, (and more difficult to explain), but rather more precise.

d. Infra-human research - in which non-human species are studied (e.g., mice, rats, drosophila, etc.). Enables one to assess the univerality of some age-related phenomena. Distinct advantages of time (due to shorter life-spans) and experimental precision (due to opportunities to manipulate both genetics and environment).

e. Cross-cultural research - in which aging phenomena are studied in a variety of cultures. A very demanding approach in terms of cost, time, coordination, and measurement, but provides a unique perspective on problems of causation in human aging - i.e., if an age-related phenomenon is replicated in very diverse cultures, it would appear to be a result of intrinsic aging processes (i.e., "culture free"). Conversly, cross-cultural research may encourage us to broaden the scope of our questions - to determine the reality (and some exciting possibilities) regarding the impact of culture on aging processes and the relative needs and well-being of various societies of older persons.

D. Suggested Instructional Methods

Predominantly lecture methods, supplemented by reading and active discussion of illustrative research studies. Students might also be asked to critique selected studies and/or design a basic paradigm for a selected gerontological research problem.

E. Bibliography

Birren, J. E. (Ed.) Handbook of aging and the individual. Chicago: University of Chicago Press, 1959, Chapter I, "Principles of Research on Aging."

Bromley, D. B. The psychology of human aging. Baltimore: Penguin, 1966.

Neugarten, B. L. (Ed.) Middle age and aging. Chicago: University of Chicago Press, 1968. "Appendixes. Research Strategies."

UNIT ONE

BIOLOGY OF AGING

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UNIT ONE

BIOLOGY OF AGING

I. General Considerations, Introduction

A. Anecdotal Information

It hardly seems necessary to describe the biology of aging, because "everybody knows" about the biological changes which occur as people get older. According to this view, aging invariably and inevitably involves a deterioration in all physical, mental, and psychological functions; after maturity things are all downhill. Most of these so-called facts are based on a few observations of individuals who made strong impressions because their conditions were extreme; a person must become very old indeed before his general good health and intellectual competence become particularly noteworthy. Furthermore, even the deterioration which does occur with aging may often be attributable to after-effects of diseases rather than simply to age. In spite of great medical progress, most of today's elderly have lived more than half their lives in a medical environment which preceded the effective control of infectious diseases by antibiotics and vaccines; it is hard to be very certain about the effects of severe diseases in childhood and early maturity on the function of individuals forty or more years later, but there are enough known situations (such as the relationship of rheumatic fever and heart disease) to arouse suspicion.

Although most students in this course will not be specifically concerned with the biology of aging, they need some understanding of the subject if they are to see social and psychological problems in perspective. Accordingly, this chapter includes a brief summary of current views on age-related changes in humans and animals, as well as a list of the major theories now or recently considered to explain biological changes in aging populations.

B. Research Approaches

There are two principal ways of looking at aging - one can concentrate either on age at death (and causes of death), or one can measure changes in various functions as age increases. Over the years, it has become increasingly apparent that improved nutrition, medical care, etc., have little effect on maximum age attained by healthy individuals of any species, but the shape of the survival curves are changed so that a larger number of subjects avoid early death and live to the maximum age; illustration of this point appears as Figure 1 in nearly every textbook of gerontology. In view of this

apparent failure of medical intervention to increase the maximal life-span for the species, there has been more and more emphasis on improving the "quality" of life within that life-span, i.e., to avoid or ameliorate the progressive loss of function which frequently accompanies aging. Thus, much of the clinical and experimental gerontological research now being done involves physiological and biochemical studies on subjects as they approach and exceed the mean life-span for their species.

1. Clinical Studies and their Limitations

The needs and interests of various medically-oriented groups, insurance companies, and government agencies provide a great deal of information on life-span and cause of death in human populations. However, it is difficult to reach valid scientific conclusions about aging on the basis of observations on individuals of unknown or uncontrolled genetic and disease backgrounds who live in an unspecified environment, eat a diet they (rather than the investigator) choose, and drop out of the experiment whenever they tire of it.

2. Choice of Model Systems

Considering the difficulties of clinical studies, it is not surprising that attempts to study aging processes have been done on animals or other model systems; the separation of variables which is essential if anything reliable is to be learned is a lot easier to achieve with mice and rats. Scientists do much careful thinking when selecting model systems they will study; they may spend many years working with them. This selection problem is obvious: the animal chosen must allow a reasonable chance that the conclusions are relevant to aging in humans, it must be sufficiently small so that feeding and housing over a lifetime will not be prohibitively expensive, and it must not have a high incidence of diseases such as tumors which would kill most individuals before normal aging processes become detectable. And, of course, it must have a relatively short life-span if longitudinal studies are to be done; it is rather difficult to design experiments in which most of the subjects outlive the experimenter.

On the basis of such criteria, many gerontologists have chosen to study aging in rats and mice. In particular, the C57BL/6 strain of laboratory mouse has been used quite frequently; it is resistant to tumors, has an average life-span in the range of 30 months, is readily available to most laboratories, and doesn't eat much. Less work has been done with rats (which are bigger, eat more, and live a bit longer), and relatively little with other species. A few investigators

have published interesting studies with very short-lived invertebrates such as the mosquito, the rotifer, and the nematode, but many gerontologists have misgivings about the applicability of such observations to mice, much less to man.

The advantages of studying cells from humans have contributed to the popularity of research on a cell culture system which has a number of interesting and useful properties. The cells were isolated from a human lung more than 20 years ago; they have maintained many important properties of their original function during this long period of storage and growth outside the donor. These cells, called WI-38, have been used for many purposes (such as vaccine production) as well as studies on aging, but they provide the basis for one of the major theories of aging - the cellular senescence theory.

II. Current Status of Biological Research on Aging

A. Relationship of Aging and Disease

As mentioned earlier, both in humans and in animals, it is very difficult to distinguish between after effects of past diseases, effects of present disease, and effects of aging itself. But the distinction is important; true effects of aging can be expected in virtually all old people, but the disease-related changes obviously will vary substantially among individuals, just as their disease history does. Furthermore, it would be bad pharmacological practice to design treatments for "aging" which are really aimed at symptoms of particular diseases not necessarily found in the majority of the aging population.

As it happens, some diseases occur so frequently among the aged that the diseases (or at least, the diminished resistance to them) might be considered part of the aging process. For example, deaths from cancer and heart disease occur far more frequently in older populations than among the young; on the other hand, the elderly are less likely to die of appendicitis or in accidents.

Thus far, clear distinctions between effects of age and of disease have not been made by most experimental gerontologists or clinical observers of the elderly. So the generalizations presented below may be the results of either disease or age. Research is now being done on mice and rats grown throughout their life-span in very carefully controlled disease-free environments, with detailed pathological examinations done at regular intervals throughout the life-span.

Studies on these animals should provide reliable information which will allow us, at long last, to eliminate effects of diseases when attempting to observe effects of age.

B. Biological Effects of Aging (+ Diseases)

1. Humans and Whole Animals

As mentioned above, causes of death at various ages are well documented for humans; cancer and cardiovascular or kidney disorders become predominant in older individuals. In the absence of obvious disease, there is a general decrease in ability to respond to stresses. Resistance to cold or blood loss, work time until exhaustion, utilization of oxygen, and many other physiological processes have been reported to be impaired in older individuals. But generalizations are particularly difficult in this area; one of the most characteristic features of aging is the increased variability among individuals.

It has been pointed out by several observers that the largest age-related decreases occur in the most complicated functions - those involving integrated responses of a number of tissues or organs. It appears that many of the aging individual's tissues suffer a decreased ability to respond to exterior stimuli, whether these stimuli come from the outside or from other tissues within the same subject.

2. Changes in Specific Tissues or Organs

It has been estimated that on the average, organ systems suffer a 1% per year decline in function when past maturity. This decline takes different forms in various tissues; the simply-observed change is not always so simply-caused. For example, the loss of size and strength in muscle may be due to at least two nonmuscular events: (1) decreased availability of oxygen in the blood because of lessened capacity and efficiency of the lungs, and (2) less exercise resulting from the quiescent role imposed on the elderly in some societies. In addition, decreases in speed of nerve impulses could also make the elderly less inclined to take active exercise by participating in various kinds of games.

The increased incidence of heart disease with age is well established. Much of it results from increased resistance to blood flow in athlerosclerosis, from which virtually all men and most post-menopausal women suffer. This partial blockage of blood vessels can, in turn, cause serious problems in brain function, as well as function of the heart and other critically-important tissues.

At least part of the loss of kidney function with age results from a lower rate of blood flow in these organs, but there are also decreases in filtration and excretion rates. Coupled with the decreased ability of the liver to detoxify foreign compounds, this means that the elderly patient can be surprisingly sensitive to some drugs.

Like the rest of the animal, the skin of the aged can be more sensitive to external shocks. Bruises form more readily and injuries heal more slowly. The texture of the skin changes and "aging pigments" accumulate to give a mottled appearance. Bones are more fragile; loss of bone mass occurs and may even proceed to the serious and painful condition called osteoporosis. In addition, joints tend to stiffen and become painful to move.

Although some of these conditions can be treated with hormones or hormone derivatives, not all endocrine functions decrease significantly with age. The dramatic decrease in estrogen secretion in females at menopause is not paralleled by similarly large changes in other hormones. In some cases it appears that the change occurs in the target tissue rather than the hormone-producing gland; there is plenty of hormone in the blood, but sometimes the older tissue does not respond as much as young tissue. There is much evidence that sexual activity can continue well beyond the age range at which younger individuals presume all fires have been extenguished.

3. Cells and Enzymes

In 1961, Hayflick first showed that isolated cells from normal human lung are not capable of unlimited growth, as had previously been thought. Unlike cancer cells in tissue culture, the normal cells stopped growing and died after 50 or 60 doublings of the cell population. This led to the suggestion that aging could result from a limitation inherent in the cells themselves, and further work has shown that the limits are indeed proportional to the life-span of the animal from which such cells are prepared. The attractiveness of isolated human cells as a model system for study of aging has prompted a good deal of study of this phenomenon, mostly in the WI-38 strain in which the original observations were made. A number of important correlations with age-related changes in whole animals have been made, and various simple technical explanations for the limitation of cell life have been disproved. It has been possible to extend the life of WI-38 cells in culture by growing them in the presence of some steroids or vitamin E, but these observations have not yet been extrapolated to treatment of elderly humans.

Many determinations of amounts of various enzymes in tissues from a number of animals at various ages have been reported. Unfortunately, no biochemical explanation of aging has emerged; some enzymes go up, some go down, and some remain unchanged. Thus far, no one has detected any rational pattern in these changes which would provide the basis for a theory of aging at a biochemical level.

Observations of changes in amounts of enzymes have been more interesting. In a number of cases, it has been shown that changes in response to certain stimuli occur less rapidly in old (compared to young and adult) rats and mice. This work, principally by Adelman, has been concerned primarily with the induction of enzymes in the liver; other investigators have shown similar deficiencies in responsiveness of heart, brain, and other tissues in several animals.

C. Theories of Aging

The observations described above have been made in all sorts of subjects by many different investigators. Only recently has rigorously controlled research been done on aging processes, and there is not yet enough information to gather it all together in a single - or even a few - theories of aging. Indeed, it is frequently remarked that the number of theories on biology of aging seems to exceed the number of reliable experiments on the subject. Although somewhat exaggerated, this quip indicates a part of the problem one encounters in considering the biology of aging; experimental gerontology is a very young field compared to many other areas of biology. In this section, I will mention several of the theories currently or recently debated by experimental gerontologists; the biologically oriented reader can find more detailed information and references to papers which describe experiments in some detail in the book by Rockstein (1974).

1. The Error Catastrophe

In the early 1960's, Orgel suggested that aging could result from an accumulation of errors in the synthesis of those proteins which are absolutely essential to normal cell function and survival. The complex mechanisms by which the inherited information encoded in the sequence of DNA in genes is converted to cellular functions had recently been discovered, and he reasoned that something so complicated might go wrong occasionally. Although biological systems are capable of repairing or eliminating some kinds of errors (rather like wound healing on a molecular scale), Orgel suggested that errors in the proteins involved in the formation of other proteins would make things look bad for the

animal; an "error catastrophe" would occur. This theory is attractive in several ways: it would give somewhat different effects in different individuals, it would be cumulative with age, and it would ultimately lead to loss of function and death when enough errors had occurred in crucial proteins.

Some data have been found to support Orgel's idea. In several cases, it has been possible to show that individual enzymes become less active (per molecule of enzyme protein) as a function of age in animals or isolated cells, and old animals have been shown to use "wrong" amino acids which younger animals treat with disdain; in other words, the protein synthesizing systems are a little less selective in old subjects. However, as procedures have been developed to allow detailed comparisons of large populations of proteins (such as are found in any cell), it has not been possible to demonstrate the large changes in protein populations which would be expected if an error catastrophe was about to occur. In addition, studies on senescent WI-38 cells have generally failed to support the error theory; it seems that this system should be particularly useful in demonstrating an error catastrophe, because there is no possibility of "corrections" by interaction with other kinds of cells as in the whole animal.

2. The Somatic Mutation Theory

The observation that ionizing radiation (and other agents) could cause changes in the DNA molecules in genes led Curtis to suggest that such changes might cause loss of cell function as they accumulated with age. In a way, this view is similar to the error catastrophe theory; in this case, the change is supposed to occur in the gene itself, not in the complex set of proteins involved in converting genetic information into cellular functions. These changes in genes not involved in reproduction of the animal would not lead to any effects on the offspring, so they would not represent mutations of the kind studied by geneticists. Observations on changes in chromosome structure provide some evidence in support of this theory, and exposure to low levels of radiation for long periods causes some changes similar to aging in experimental animals. But like many theories of aging, this one has more weaknesses than strengths; radiation damage differs from aging in many easily discernible ways, and agents which protect animals from radiation damage do not prolong life beyond the maximum attained in normal healthy individuals. Even the involuntary experimental subjects from Hiroshima and Nagasaki have exhibited no acceleration in aging as a result of their exposure to a lot of radiation.

3. Cellular Senescence

The demonstration of limited proliferative capacity in normal (as opposed to cancerous) human cells led Hayflick to suggest that life-span limits may be a property of the individual cell which is then expressed as aging in the animal those cells comprise. The WI-38 system has been particularly attractive; the advantages of working on human cells rather than animal models is obvious. The system has been valuable for the evaluation of a number of theories of aging. However, in spite of the importance and experimental usefulness of cellular senescence observed in WI-38 cells, this approach to aging has not yet provided answers to the problems of gerontology. In fact, this is really an observation, not a theory or a proposed mechanism; all that has been done is to shift the question from "What makes animals age?" to "What makes cells age?" Although the latter is, in fact, much easier to investigate, answers have not yet appeared with breathtaking rapidity. Furthermore, the general significance of mechanisms established in isolated cells in tissue culture must remain rather questionable until they are explored in whole animals as well. In an intact animal, many tissues are called "postmitotic" because little or no cell division occurs in them after maturity; this is true of muscle, brain, heart, and the nervous system. These tissues are not exactly immune to senile deterioration. It seems that another mechanism must be found to account for aging in postmitotic tissues; it is unlikely that these tissues deteriorate as a result of the loss of a proliferative capacity that they weren't using anyway.

4. Impaired Enzyme Induction

Adelman's demonstration that elevation of many liver enzymes is delayed in older animals has attracted the interest of many biochemically-oriented gerontologists. Unlike many cases in aging studies, data accumulation here seems to be preceding the formulation of detailed theories, and no grandly-titled proposal has appeared. In fact, as in the case of cellular senescence, these observations represent a description of aging, not an explanation of the process. Nevertheless, this progressive unraveling of the biochemical factors limiting the responsiveness of various tissues, as well as growing awareness that "age decrements are greater in performances which involve the coordinated activities of a number of organ systems," (Shock, 1974) indicates a probable direction of research progress in gerontology in coming years.

5. Other Theories

There are a number of other less widely considered views of aging which have not achieved the attention gained at one time or other by those described above, but which are actively pursued by some research groups. Such processes may contribute significantly to the mechanisms of cellular senescence, impaired adaptation, or other age-related change for which no mechanism has yet been discovered. They are covered in some detail in various sections of the book by Rockstein (1974), and in less detail as indicated in the bibliography. The auto-immune theory suggests that the body gradually loses its ability to differentiate between its own and foreign proteins, and so begins to make antibodies to its own protein; the resultant inactivation of the proteins causes loss of their functions and leads to deterioration and death. The cross-linking theory suggests that damage to important large molecules (primarily DNA) results from chemical reactions which attach adjacent molecules to each other and thus prevent important functions which require separation of these molecules. The free radical theory is a special case of the cross-linking theory; it suggests a specific type of chemical cross-linking agent. (Nonchemists should understand that "radical" has a chemical, not a political significance in this case). The endocrine deterioration theory combines the obvious importance of hormones to physiological function with the well-known loss of endocrine function in menopause; the wild extrapolation from the ovary to all other endocrine glands is not supported by the experiments which have been done to test this theory.

Finally, the programmed theory of aging indicates that aging is an inherent process dictated by the genetic inheritance just as all other aspects of development from the moment of conception. Like the cellular senescence theory, this is an "internal" rather than an "external" view of the aging process - aging is an inescapable consequence of life, rather than a result of exposure to radiation, free radicals, disease, bad nutrition, or other outside agents. The strong relationship between life-span and species, correlation of life-span within families, etc., indicate that there is some relation of genetics and life-span. Unfortunately, it is not possible to avoid the argument that this relationship results from a greater ability of the long-lived groups to combat the deleterious effects of the environment. Finding acceptable theories of aging really isn't easy.

III. Future of Aging Research in Biology

As work progresses and knowledge accumulates, more reliable information on the nature of the nature of the aging process(es) will become available. Formation of the National Institute of Aging will be an important factor in unifying many diverse sources of information and materials. For example, a special set of disease-free rats and mice has been established for the use of scientists who can study aging processes in the absence of after-effects of diseases. (In fact, much of the older research on aging is not useful because the animals were suffering from one or more diseases at the time of the experiments, so we cannot be sure which changes resulted from aging and which from the disease). In the near future, it appears that studies on cellular senescence and impaired enzyme adaptation (and related biological control phenomena) will be the most actively pursued. As more sophisticated aging information is obtained, it will probably be recognized that many factors contribute to the process we call aging; indeed, it seems possible that all of the theories of aging described above are correct in the sense that they describe an important aspect of aging, but incorrect in that they do not describe all of the phenomenon. Biological gerontologists are working actively in attempts to achieve useful understanding of aging before they themselves become suitable subjects of study.

IV. Suggested Instructional Objectives

The objectives for the unit might be to:

1. Gain an appropriate biological perspective for dealing with the social and psychological problems of the aged.

    a. Distinguish effects of aging from symptoms or after-effects of diseases.

    b. Separate anecdotal tales from established scientific information on the aging process(es).

    c. Become aware of the large variations among individuals which characterize an aging population.

2. Develop an understanding of the nature and limitations of current knowledge of the biology of aging.

a. Be able to recognize the distinction between clinical and experimental approaches to gerontology and the advantages and disadvantages of each.

b. Become familiar with the model systems used in experimental gerontology and the considerations which led to their selection.

c. Gain an awareness of current knowledge of age-related changes observed at various levels of biological organization - in whole animals, individual tissues and organs, cells in culture, and enzymes.

d. Understand the tenents, experimental bases, and weaknesses of current theories of aging.

3. Be alerted to the nature, direction, and significance of future research on aging.

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UNIT ONE

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Comment on Books Regarding Coverage of Biology of Aging:

Atchley. (pp 43-51) Brief, outdated, rather naive coverage of the theories of aging. Reasonably good description of effects of age - within limits of short length used.

Boyd. (pp 51-76) Emphasis on medical treatment with specific information on changes in individual organs, suggestions for handling each. No consideration of experimental gerontology.

Curtin. (pp 14-26) Very generalized, popularized, incomplete. Readable and entertaining, but not intended to be scientifically informative.

Neugarten. No coverage of biology, except occasional brief mention when related to other topics.

Palmore. (pp 28-74, 167-193) Much clinical information, good basis for perspectives on actual incidence of various problems as they would be encountered in the field. Comprehensive clinical data, no coverage of experimental gerontology.

Riley and Foner. (Vol. 1, pp 187-240) Rather bald presentation of data with little interpretation, but vast quantities of data. Useful source of specific data to illustrate points. Organized well for easy accessibility. No experimental gerontology.

Woodruff and Birren (pp 201-278) Somewhat more advanced than the others, perhaps most suitable for a college text. Good, authoritative, up-to-date coverage of experimental and some clinical gerontology.

UNIT TWO

PSYCHOLOGY OF AGING

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UNIT TWO

PSYCHOLOGY OF AGING

I. Introduction to Psychology Content Area

While the order in which you present the topics in the psychological aspects is up to you, it is suggested that you begin with psychomotor performance and then intellectual functioning, learning, personality and adjustment, and finish with mental health. In terms of conceptualization, starting with psychomotor performance introduces many concepts which recur in the other areas.

The issues, concepts, and information presented in each of the content areas are designed to give your students a background of the fundamental age-associated changes in psychological functioning. Each area can be expanded into a semester-length course; thus, the information presented should not be considered exhaustive.

Without question, the single most important issue in the psychology of adult development and aging is the effect of health status and chronic diseases on psychological functioning. If health is not considered, the results of research projects could very well over-estimate the influence of the aging process on psychological functioning.

II. Objectives for Psychology Content Area

The overall goal is to acquaint the student with the basic knowledge base in gerontological psychology. To this end, the following objectives are suggested.

1. To understand that the slowing of responses in older adults is an all-pervasive phenomenon which reflects normal age changes in the central nervous system.

2. To understand that disease processes such as coronary artery disease and hypertension are critical factors pacing much of the age-associated change in psychological processes.

3. To know that intellectual functioning is altered by the aging process and that there is both stability and decline in cognitive abilities.

4. To understand the influence of cohort-specific factors on age-associated change in psychological processes.

5. To be aware of the effect of terminal decline on measurement of intelligence.

6. To understand the different theoretical approaches to explaining age changes in intelligence.

7. To understand that the older adult is quite capable of learning new material but does require a longer time in which to learn.

8. To be aware of the effect of pacing on learning.

9. To know the difference between disengagement and activity theory and their weaknesses.

10. To understand the results of the major studies of adult personality.

11. To appreciate the critical importance of a confidant.

12. To understand the life review process.

13. To appreciate the interaction between physical disease and psychiatric disability during senescence.

14. To understand the differences and implications of the medical and psychosocial models of geriatric psychiatry.

15. To be aware of different treatment modalities available to geriatric patients.

16. To be aware of the various alternatives to institutionalization.

17. To be aware of the causes of depression in the elderly.

18. To understand the influence of social factors in the mental health of older adults.

III. Psychomotor Performance

A. Overview

One of the most prevalent findings in the geropsychology research literature is the slowing of response speed and the generalized slowing of speed and timing of behavior with age. Research has shown that whether the stimulus was auditory or visual, simple or complex, older persons showed significant slowing of behavior compared to younger adults. This is true even of persons in their 40's and 50's.

From the initial perception of the stimulus to the completion of the required response, there are many complex phases which affect reaction time or the speed of response. Some of these factors include sensory acuity, speed of nerve conduction, length of neuromuscular pathway, as well as such factors as preparedness, sex differences, learning, and maintaining a set to respond. It is important to stress to your students that while these factors do relate to age differences in psychomotor performance, without doubt the most important factor is the change in the ability of the brain to process stimulus information and initiate appropriate response.

Perhaps the most important factor influencing and exacerbating slowing of response speed with age is coronary artery disease. Persons who have suffered and recovered from coronary disease have significantly slower reaction times and psychomotor performance than persons of the same age who are free of coronary disease.

Spieth studied the psychomotor performances of more than 600 men aged 25-60. The men were divided into groups on the basis of cardiovascular health status: (a) strictly healthy, (b) recovered from coronary heart disease, (c) medicated hypertensives, (d) unmedicated hypertensives, and (e) cerebrovascular disease. Spieth found that there was significant slowing of reaction time with age in all groups. But he also found a profound effect of health status on performance independent of aging. Spieth felt that much of the observed age-associated slowing of response time could be attributed to disease processes that are correlated with age. Thus, both age and health status influence speed of responding.

Another impoartant physiological factor which seems to affect reaction time is the frequency of the alpha brain waves as recorded by the electroencephalogram (EEG). The cells of the brain give off small charges of electrical activity which are measured in cycles per second. The dominant electrical activity of the cerebral cortex is alpha. Surwillo has hypothesized that the alpha rhythm mediates the speed and timing of all behavior and that a slowing of alpha would cause a slowing of response. In general, older persons tend to have slower alpha frequencies than younger persons. According to Surwillo this would result in the observed slower reaction times of older persons.

Another point which you should transmit to your students is that as the complexity of the stimulus or response increases, the reaction time slows. This is true of persons of all ages; however, the elderly show disproportionate slowing.

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There are several important implications, both scientific and practical, of response slowing. In terms of psychological performance, slowed response speed affects cognitive and perceptual functioning. In terms of daily activities, slowed reaction time plays an important role in accidents and falls, as well as everyday skills such as driving.

Depending on how much time is available or how much time you wish to devote to the topic of psychomotor performance, the following areas can be covered in order. Any of the areas can be expanded or taught at any level of difficulty.

If there is one single piece of information which your students should have it is that slowing of behavior and slowed response speed is one of the most fundamental aspects of the aging process. If the older person also suffers from chronic disease, e.g., coronary artery disease, then there is even further slowing.

B. Topic Outline

1. Reaction time (1)*
   a. Represents a measurement of the speed and time of behavior
   b. Outward manifestation of the information processing ability of the central nervous system
2. Physiological correlates
   a. EEG alpha frequency (2)*
      1) Surwillo's hypothesis relating alpha to reaction time performance
      2) Evidence for and against the hypothesis
   b. Coronary artery disease (3)*
      1) Both coronary disease and uncontrolled hypertension correlate with slowed reaction time
      2) Older persons are more likely to suffer from coronary disease and hypertension
3. Implications of slowed response speed for daily activity (4)*
   a. Accidents and falls
   b) Driving

*Numbers in the outline are keyed to the bibliographic references.

4. Important individual factors in age-associated response slowing (5)*

   a. There is great individual variability in response speed. This variability appears to increase with age; i.e., as people age the variability between them in the speed with which they respond to stimuli increases

   b. Both practice and motivation to perform well will affect reaction time of all persons but especially the elderly

5. External factors affecting age differences in reaction time performances

   a. All persons respond faster when they are given a warning signal compared with when no signal is given. However, this is especially true with older people.

   b. The inability of older people to maintain a set or attentional focus to respond plays a role in age differences in reaction time.

   c. Other factors which influence age differences in response time include the complexity of the stimulus, the duration of the stimulus, the complexity of the response, and the number of choices presented.

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UNIT TWO

IV. Intellectual Functioning

A. Overview

Perhaps no other area of the psychology of aging has undergone greater reconceptualization than intellectual performance and intelligence. Major changes in research methodology and the conflicting results of longitudinal and cross-sectional studies have forced researchers to reexamine previous assumptions about age changes in intellectual performance. Further, research relating health status to intellectual performance has demonstrated the need to qualify statements and generalizations about elderly persons.

There are several concepts and basic pieces of information which your students should master. The first is that despite the voluminous investigations of adult and older adult intelligence that have been conducted over the past 25 years, there is no adequate nor accepted criteria for the measurement of intelligence in adults. The criterion against which the intellectual performance of children and adolescents is measured is scholastic achievement; i.e., success in school. For adults and for the elderly there exist no similar criterion. Thus, there is a real problem as to the meaning of adult intelligence outside of the actual testing situation.

Much confusion regarding adult and older adult intellectual functioning stems from apparent differing results from longitudinal and cross-sectional studies. The cross-sectional method, which is by far the most prevalent research design in gerontological psychology, studies two or more groups of subjects of different ages at the same time. The longitudinal design studies a single sample of subjects of the same age across time; e.g., one year, four years, ten years. It has been the usual finding that cross-sectional studies find greater age-differences in intellectual abilities and show earlier ages at which the observed decline begins. This is a result of a natural over-estimation of the effect of aging in cross-sectional studies. That is, these studies exaggerate factors related to age which influence age-associated intellectual functioning such as education and health.

Longitudinal studies have shown that there are increments in intelligence with age in measures of verbal intelligence and stored information such as vocabulary, general information and comprehension. Decline in intellectual functioning is seen in measures of nonverbal abilities.

Very clearly there are both increments and decrements in intellectual functioning as a consequence of the aging process. There are, however, factors which are correlated with age, but not caused by age, which influence the performance of older people on tests of intelligence. Clearly, the most important of these factors is education. Results of studies suggest that the educational level of a person is more important than age in regard to general mental ability. In studying the effects of age on intellectual functioning it is important to evaluate the effects of education. It must be emphasized that failure to control or remove the effects of education by statistical or experimental means exaggerates the decremental effects of aging since older people tend to have fewer years of education.

Another factor which significantly influences intellectual functioning is health status. Two important studies show the effects of cardiovascular diseases on age-associated intellectual functioning. Birren, et al., intensively studies 47 healthy old men, measuring a variety of medical, psychological and social variables. These men were divided into two groups on the basis of health. Twenty-seven were considered to be in in optimal health, while the remaining 20 were found to have mild, asymptomatic or subclinical signs of disease, especially arteriosclerosis. The two groups differed significantly on many of the variables. The optimally healthy group was significantly superior to the subclinical group on 21 of 23 tests of verbal intelligence of stored information. Additionally, the subclinical group tended to be somewhat slower in response time than the healthier group. Interestingly, the healthier group showed superior verbal scores compared to a group of young adults. This study demonstrated that there are both increments and decrements in intellectual functioning associated with the aging process as well as decrements in functioning associated with even mild disease states.

Another important study was conducted by Wilkie and Eisdorfer on the relationship between hypertension and age-associated decline in intellectual function. When older adults were divided on the basis of whether or not they showed chronically high blood pressure it was found that the hypertensive subjects showed significantly poorer intellectual performance than those with normal blood pressure. Thus, it can be seen that health status is a very potent variable influencing age-associated intellectual decline. Both hypertension and cardiovascular disease are highly correlated with age.

The concepts of terminal decline and critical loss are of major importance in any discussion of intellectual functioning of older adults. In longitudinal studies a relationship has

has been found between survival during senescence and performance on tests of psychological abilities. All longitudinal studies have found that those participants who died prior to retest, or for other reasons were not available for follow-up, showed poorer scores at initial testing than those who survived. This has been shown for a variety of psychological measures including intellectual abilities.

The lower initial scores of the nonsurvivors has been attributed to a decline from a previous higher level of ability rather than any inherently lower ability. That is, rapid decline of intellectual functioning appears to be related to near-future occurrence of disease and possibly death. In fact, Jarvik and Blum have computed a critical loss factor based on an annual rate of decline in abilities which is predictive of nonsurvival.

Another major reconceptualization which has occurred involved the shift from a descriptive model of intelligence to a factor analysis model. The descriptive model is derived from the formulations of Wechsler and the use of the WAIS. This basically describes adult intelligence in terms of a verbal I.Q., a nonverbal I.Q. and a full scale I.Q.

The factor analytic model attempts to define adult intelligence in terms of specific abilities. This model derives from the work of Horn and Cattell who have organized intelligence in terms of crystallized and fluid abilities and postulate mechanisms mediating each factor.

It is felt that aculturation mediates crystallized abilities and, thus the greater exposure one has to one's culture the more superior will be crystallized intelligence. It is felt that biological factors mediate fluid abilities and thus changes in physiological functioning due to disease and/or aging would negatively influence fluid intelligence.

Discussion of the descriptive and factor analytic models can become quite complex, so unless your students are at least equivalent to college sophomores you would be best advised to just mention that there are two models.

There is a very important intersection of slowing of response speed and the measurement of intelligence. All tasks which measure nonverbal intelligence and fluid abilities involve a component of speed. That is, the score is based not only on correctness but also on the speed with which the task is completed. Given the slowed responding speed of elderly persons, their performance will naturally show a decrement, both when compared cross-sectionally and longitudinally.

There are two basic theoretical approaches to the study of age changes in adult intelligence. The most recent model is based on environment and holds that environmental and social factors are the major cause of age-associated changes in intellectual functioning. Proponents of this model feel that much of the observed decrement of the elderly is a result of preventable environmental factors and also that much is reversible.

The other model is a purely biological one and holds that biological mechanisms mediate intelligence. Health, brain function, heart disease, and hypertension all influence intellectual performance in older adults.

Depending on how much time is available or how much time you wish to devote to intellectual function, the following topics should be covered in order and can be expanded depending on time and level of student ability.

B. Topic Outline

1. Adult Intelligence
   a. Meaning of I.Q. (1)*
   b. Lack of criteria for adult intelligence (1)*
2. Classic pattern of age changes in adult intelligence
   a. Increments and stability in verbal measures (3)*
   b. Decrements in nonverbal measures (3)*
   c. Importance of education (4)*
   d. Role of speed of responding
3. Health status
   a. Biological mechanisms mediate intelligence
   b. Health: 47 healthy old men study
   c. Cardiovascular diseases (11)*
   d. Terminal decline (12)*
4. Models of adult intelligence
   a. Descriptive approach (5)*
      1) WAIS
      2) Verbal
      3) Nonverbal

*Numbers in the outline are keyed to the bibliographic references.

b. Factor analytic approach (6)*

1) Horn and Cattell

2) Crystallized abilities

3) Fluid abilities

5. Behavioral approach (8)*

a. Social and environment factors

b. Reversibility of decline

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V. Learning

A. Overview

It is commonly thought that learning ability declines in later life. This may not be true. Clearly performance aspects of learning tasks tend to be poorer in later life than in young adulthood. The speed with which an older person can respond limits his ability to demonstrate what he has learned and is not in itself regarded as a cognitive factor. In discussing the learning ability of older adults you should make certain that your students understand the difference between cognitive and performance factors.

The research strategy most often used to assess learning in older adults is the paired-associates verbal learning paradigm. This requires subjects to learn pairs of words under various conditions which impose time constraints on the learner. Also, serial rate learning tasks have been employed. In this task the subject is required to learn a list of words.

Probably the most important variable which affects performance of older adults on learning tasks is pacing. Pacing refers to the external constraints placed on the amount of time the stimulus material is presented and the amount of time during which the subject must make a response. This is opposed to self-pacing in which the subject is allowed to control the time constraints himself.

Under conditions of external pacing of the stimulus material, older adults show considerable deficits in learning. That is, they make more errors during the learning task and require more trials to learn the material perfectly. The faster the pacing, the greater is the age differences in learning performance.

One of the issues regarding pacing concerns whether limiting stimulus presentation or limiting the amount of time allotted for responding is more inhibiting for the older learner. Several studies have indicated that older subjects tend to increase the time to respond but not the time to study when given the opportunity to do both.

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There are other noncognitive factors which appear to affect the performance of older persons on learning tasks. These include motivation, physiological arousal, the meaningfulness of the task, and whether or not the task requires organization of the incoming information. Depending on the amount of time you wish to devote to learning in older adults, these other noncognitive factors can be discussed. You will probably find that, at a minimum, a second-year college level will be required for your students to fully grasp these latter factors.

Even though these noncognitive performance-related factors are important, there is still clear support for the proposition that there is cognitive deficit affecting learning ability in the elderly. One line of evidence concerns the types of errors made by older subjects in the course of learning verbal material.

In any learning task a subject may make an error of commission or an error of omission. That is, either make the wrong response or make no response at all. Errors of commission are felt to represent the cognitive component and errors of omission are felt to represent the performance component of learning tasks. Studies which have focused on the kinds of errors elderly subjects make have indicated that even with sufficient time to respond, errors of commission abound.

You should stress to your students that those studies which focus on both the cognitive and performance aspects of learning have shown that there are both cognitive deficits and performance deficits associated with older adult learning. Performance plays a role in young adult learning as well, but is especially important in studies with the aged.

B. Topic Outline

1. Parameters of adult learning (1)*
   a. Cognitive ability: errors of commission
   b. Performance as external from learning: errors of omission.
2. Verbal learning (2)*
   a. Paired associates
   b. Serial rote

*Numbers in the outline are keyed to the bibliographic references.

3. Pacing (3)* (4)* (5)*
   a. Stimulus presentation
      1) Inspection or study time
      2) Self versus external pacing
   b. Response pacing
      1) Time allocated for making response
      2) More critical for elderly than for young

4. Other noncognitive factors
   a. Motivation (6)*
      1) Desire to perform as well as possible
      2) Involvement in task
   b. Task meaningfulness (7)*
      1) Personal relevance
      2) Familiarity of task
   c. Physiological arousal (8)*
      1) Autonomic nervous system responsivity
      2) Response limitations and arousal

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UNIT TWO

VI. Personality and Adjustment

A. Overview

One of the central themes revolving around the study of personality in later adult years is concerned with the factors related to successful aging. Associated with this concern has been the issue of life style or activity patterns.

An early formulation of the relationship between activity patterns or life style and adjustment to old age was the activity theory. As proposed, this theory conceptualized successful aging as a maintenance of middle age interests and activities even in the face of biological decline. This resulted from studies which showed that older persons themselves felt that the proper activities of old age were the same as for middle age. That is, the norms for behavior during old age were the same as those of middle age.

A later theory proposed just the opposite relationship between adjustment and activity patterns. The disengagement theory held that as people get older, there is a mutual withdrawal or disassociation of the individual from society and society from the individual. Furthermore, this mutual disengagement was both natural and desirable for successful adjustment to old age. The theory stated that the disengaged person is a happy one and, if pushed into activity, morale and life satisfaction will suffer. This formulation was derived from the early data from the Kansas City studies.

Quite naturally this led to contradictory positions and thus controversy. However, the later analysis of the Kansas City data seems to have resolved the problem, at least somewhat. It appears that the crucial variable is the maintenance of life-long patterns of activity or nonactivity. That is, a person with a life-long pattern of disengagement is most satisfied in old age being disengaged; the converse is also true.

The Kansas City studies also showed that personality type rather than life style or activity pattern, was the crucial factor in successful adjustment to old age. The studies discerned four basic personality types, each of which was associated with varying levels of activity. If life satisfaction can be a criterion for successful aging, two of the personality types were associated with adjustment and two with maladjustment.

The integrated and the armored-defended personality types were associated with life satisfaction. They both showed a range of activity patterns. The passive-dependent persons had

very strong needs to rely on someone for emotional support. Also, many of these persons were very passive in their relations with others. The unintegrated personalities were the most maladjusted group and even showed deterioration of thought processes.

The Kansas City studies also focused on the intrapsychic and socio-adaptational aspects of adult personality and found very interesting results. When interest was centered on the intrapsychic processes it was found that the older adults showed greater concern with inner life feelings and less concern for persons and things in the social world. This has been termed an increasing interiority of the personality. This represents a redistribution of the energy of the ego from external to internal concerns. It was also found that there was a general decrease in ego energy and a shift from active to passive mastery of problem solving.

When the interest of the investigator was focused on the more overt, socioadaptational processes, it was found that there was a great deal of consistency in the adaptive, goal directed, and purposive qualities of personality. That is, the way in which people interact with their environment and engage in social interaction remains very consistent.

The Kansas City studies also showed that there was a shift in sex-role perceptions. Older adults perceived the roles of men to be more affective and those of women more instrumental than earlier in the life cycle. Also the dominance relationship between husband and wife shifted in favor of a more dominant role of women and more submissive role of men.

The Kansas City studies were not the only investigations of adult personality. The Berkeley Study of Retirement found that five clusters of persons have similar personality profiles. Among the five groups, three appeared to be associated with adjustment and two with maladjustment.

The first of the adjusted types was termed mature and were characterized as having a constructive approach to life. Another successful type, the rocking chair, tended to lean rather heavily on other people. The third type, who had well-developed ego defenses were very active and engaged in many activities.

The first of the poorly adjusted groups was the angry. These people were hostile and blamed their shortcomings on other people. The most poorly adjusted group were the self

haters. These people tended to blame themselves for shortcomings to an excessive degree; they also showed signs of depression.

There is an obvious consistency between the Kansas City studies and the Berkeley study. This gives further credence to the findings of each. This is something of which your students should be aware.

There is more data to support the notion that there is a great deal of continuity across time in adult personality. One's self-description of personality remains fairly consistent over even very long periods of time. There is a great deal of stability in the way in which persons describe themselves in terms of personality traits.

Another aspect of personality that is particularly stable is cognitive style; i.e., the style in which an individual perceives stimuli and attempts to solve problems. However, since cognitive style is in some ways dependent on cognitive functioning, much of the observed stability in style may be due in part to stability in cognitive processes.

One of the most important features of adjustment during old age is the presence of a confidant; someone with whom a close relationship exists. A confidant serves as a buffer against losses such as loss of role or a decline in social interaction. Persons with a confidant are less likely to be depressed and more likely to be satisfied than those without confidants. However, a confidant does not seem to buffer the individual against the psychological effects of physical illness.

Also, the loss of a confidant has a more negative effect on morale than any other social losses. This is not only because the confidant was an important person to the individual, but also because of the results of the loss of a confidant.

Another critical factor in the adjustment of older persons is stress; i.e., psychosocial stress. Research clearly indicates a very impressive relationship between psychosocial stress and mental and physical health. The greater amount of stress experienced, the greater the risk of illness.

Additionally, adjustment is often conceptualized in terms of adaptation to stress. Elderly persons are inherently under a great deal of stress in terms of withstanding the multiple social losses that accompany aging. Retirement can often bring with it significant losses in terms of roles, status and income.

This in itself is extremely stressful. Add to this biological decline and physical illness, and the stress picture of old age becomes evident. Given the greater frequency with which the aged are exposed to stress, their coping mechanisms are continually being strained. If the stress load is greater than the ability of the person to adapt to it, then illness of one form or another is likely to result.

Quite clearly there must be some mechanism which mediates the stress/illness relationship. This mechanism centers around the physiological response to stress which is really beyond the scope of this course.

A more theoretical approach to adult personality stems from a reformulation of Erickson's epigenetic theory of psychosocial development by Peck. This discussion might be more appropriate to advanced students due to the complexity of the concepts involved. According to this expanded position, there are some basic shifts in the concerns of individuals. The first is seen as a shift from work-role preoccupation to a concern with ego differentiation. That is, the identity of the self becomes less centered on work role and increasingly centered on a broader range of role activities.

A second shift occurs with the increased concern for body transcendence compared with body preoccupation. This recognizes that physical decline occurs, but also takes account of other features of the person which may increase with aging.

The third area concerns a shift from ego preoccupation to ego transcendence. This shift is accomplished only when the individual first accepts the quietness of his life and then begins to accept the personal content of that life.

This third shift is essentially involved in the life review. Life review is a natural, universal mental process prompted by the realization of approaching death. It potentially proceeds toward personality reorganization, including the achievement of wisdom, serenity, and increased self-awareness. The process involves a re-evaluation of the content of one's life in terms of the manner in which it was actually lived.

The life review involves a re-examination of personal relationships; parents, siblings, children, significant others. This can be a very painful process, especially if it proceeds in isolation.

Many of the overt behaviors associated with life review may appear to be rather bizarre to younger persons. Such behaviors as poor memory for recent events but excellent memory

for distant events, retelling a story, mirror gazing, and calling persons by the wrong name are common to life review.

B. Topic Outline

1. Successful aging (1)*
   a. Life satisfaction
   b. Activity patterns
2. Theories of successful aging (2)*
   a. Activity theory
      1) Maintenance of middle age interests
      2) High level of activity
   b. Disengagement theory
      1) Mutual withdrawal of individual and society from each other.
      2) Forced activity is dysfunctional
3. Kansas City Studies (3)* (5)*
   a. Personality is the crucial dimension for life satisfaction
   b. Intrapsychic processes
      1) Greater interiority of personality
      2) Lessened ego strength
      3) Passive mastery
   c. Socioadaptational processes
      1) Much continuity with aging
      2) Adaptive, goal directed properties
   d. Sex-role perceptions
      1) Affective/instrumental shift
      2) Dominance shift
4. Personality types (3)* (4)*
   a. Kansas City typology
      1) Integrated
      2) Armored-defended
      3) Passive-dependent
      4) Unintegrated

*Numbers in the outline are keyed to the bibliographic references.

b. Berkeley Study
   1) Mature
   2) Rocking chair
   3) Armored
   4) Angry
   5) Self-haters

c. Life Satisfaction/Activity Patterns
   1) Neither activity nor disengagement alone is satisfactory
   2) Successful aging is composed of persons who are both active and disengaged

5. Personality Continuity (6)*
   a. Self-description of personality
   b. Cognitive style

6. Confidants (7)*
   a. Crucial for adjustment
   b. Does not buffer against physical illness
   c. Loss of confidant is most traumatic social loss

7. Stress (8)*
   a. Relationship between stress and physical and mental illness
   b. Adjustment conceptualized as adaptation to stress
   c. Psychosocial stresses of aged are multiple and frequent

8. Peck's reformation of Erikson (9)*
   a. Ego differentiation/work-role preoccupation
   b. Body transcendence/body preoccupation
   c. Ego transcendence/ego preoccupation

9. Life Review (10)* (11)*
   a. Natural, universal process
      1) Leads toward personality reorganization
      2) Wisdom, serenity

*Numbers in the outline are keyed to the bibliographic references.

b. Re-evaluation of content of life

c. Re-examination of personal relationships

d. Overt behaviors

1) Reminiscence

2) Memory for distant events but not for recent events

3) Misnaming people

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VII. Mental Health

A. Overview

Perhaps no other area of gerontological psychology is as misunderstood or as fraught with myths as mental health. The most widespread myth is that of senility. Other myths and misconceptions concern the etiology and prognosis of mental disorders of older adults.

As popularly conceived, there is no such thing as senility. There are two reasons for this which your students should understand. First, the symptoms of senility are not unique to older adults. Many persons of all ages who are severely disturbed show the same behaviors as those termed senile when they occur in older people.

Secondly, the psychopathological condition known as senile psychosis is a disease process having nothing to do with normal aging. This is actually a chronic organic brain syndrome, probably a derangement in brain metabolism, which causes deterioration of brain cells. It is only when this disease state exists that the term senility is appropriate.

There are two basic models or approaches to the mental health of older adults. The first is the traditional medical model which focuses on the disease aspects of geriatric psychiatry. The second is a psycho-social model which focuses on the environment or social context as the basic cause of emotional problems of the elderly. It is important to keep in mind that these models are not mutually exclusive. They do, however, influence one's perspective on the treatment aspects of mental health.

The medical model relies heavily on medication in the form of tranquilizers, sedatives, etc., in the treatment of emotional disturbance. This model also conceptualizes as irreversible much of the behavioral disturbances which accompany psychotic states in geriatric patients.

On the other hand, the psychosocial model emphasizes behavioral therapy approaches to the treatment of geriatric psychiatric patients. The model holds that much of the behavioral disruptions are reversible and that the use of reinforcement and structured environment techniques are the most appropriate methods.

At this point, before you begin discussing organic brain syndrome, you might want to ask your class what they think is

the percentage of elderly who are institutionalized; i.e., nursing homes, psychiatric facilities, etc. You will probably be startled at the range of guesses; usually between 10% to 30% with most guessing over 20%. Most are quite surprised when you tell them that the percentage is only between 4% and 8%. However, this percentage rises rapidly, so that approximately 25% of those 85 and older are institutionalized.

A very effective way to introduce the general topic of geriatric psychopathology is to show the very strong association between psychiatric and physical disabilities. The studies have shown that about 80% of admissions to a geriatric psychiatric facility were rated as moderately to severely physically disabled. This is especially true where the older adult is being admitted to a psychiatric facility for the first time. The implication, of course, is that the majority of severe geriatric psychopathology may represent the behavior manifestation of disease processes affecting the whole body.

Depending on the amount of time available, you may wish to discuss Peck's disease and Alzheimer's disease. These two diseases are rather rare and appear to have a high heredity factor. The symptoms of these diseases are very similar to other psychopathologies of old age but they occur much earlier; e.g., early or middle fifties.

The chronic organic brain syndromes have a variety of causes. The characteristic signs and symptoms of organic brain syndrome include impairment of orientation for time place and person; defects in memory and cognitive function; and emotional disturbances.

One of the major causes of chronic organic brain syndromes is cerebral arteriosclerosis. Psychoses of this nature most frequently occur after the age of 70 and are more common in males than in females. Vascular pathology is not confined only to the brain, but is usually found in other parts of the body. The appearance of symptoms is sudden with confusion, incoherence and restlessness most common.

Cerebral vascular insufficiency is a second major cause of organic brain syndromes. This condition exists when the blood supply to the brain is inadequate to meet the metabolic needs of the brain. It may be present continuously or intermittantly when the blood flow falls below acceptable levels.

The third major cause of the organic brain syndromes is senile brain disease. The etiology of this condition is not

known, but it seems to represent an acceleration of a normal aging process. Post mortem examination of the brains of deceased patients with this disease show structural brain changes similar to those which normally occur with aging.

A variety of drugs have been used to treat geriatric patients with psychiatric disturbances. While some of the drugs have been moderately successful in ameliorating some of the behavioral dysfunctioning, there has been much less success in reversing the disease process. Depending on the diagnosis, any of the following types of drugs might be given: cerebrovascular dilators, which increase the diameter of the arteries of the brain; psychotropic drugs, such as tranquilizers or sedatives; and anticoagulants, which "thin" the blood.

Another mode of treatment for geriatric psychopathology is the use of hyperbaric oxygen. Patients are exposed to an atmosphere of pure oxygen under pressure 2.5 times that of air at sea level. This forces more oxygen into the blood and thus a richer blood reaches the cells of the brain.

Another treatment technique which is becoming increasingly more prevalent is reality orientation. This technique is derived from behavior modification procedures which use positive reinforcement to reinstate appropriate behaviors. The target behaviors can range from simple time, place, person orientation to basic social and personal hygiene skills to more complex social interaction behaviors. The specifics of this technique are tailored to the individual needs of each patient.

One particularly pressing issue regarding the mental health of older adults is existing or potential alternatives to institutionalization. For purposes of this content area only, alternatives to psychiatric institutions will be discussed. Alternatives to extended chronic care facilities are beyond the province of this topic. It must be remembered that there is a high association between emotional and physical disorders among the elderly.

The actual and potential alternatives include geriatric day care and outpatient services associated with psychiatric facilities and home care services. Day care facilities provide semi-custodial, social support and behavior therapy services for geriatric patients during the day. At night the older person returns home.

Outpatient clinics at psychiatric facilities provide psychotherapy, behavior therapy, occupational, physical, and

recreational therapies for older patients. The patients live at home and receive prescribed therapy as outpatients.

Home care services provide paraprofessional assistance to essentially home-bound elderly. The services range from custodial - companionship to home nursing and training of both patient and family. Home care for the emotionally disordered elderly is a potential rather than an existing alternative.

The psychosocial model emphasizes the role of the environment and social interactions in leading to disturbed behavior. One of the most interesting variations of the psychosocial model is the Social Breakdown Syndrome. The SBS is a seven stage formulation which describes a negative cycle of events which ultimately could lead to disordered behavior or negative psychological functioning.

The first stage of the SBS is a susceptibility on the part of the elderly to the syndrome. This susceptibility stems from social attitudes toward aging and the aged and the apparent lack of age-norms for the elderly. Once a person becomes predisposed to the syndrome, the further stages become more likely.

The second stage is a dependence on other people for the cues for current behavior. Stage three is the social labeling of the older person as incompetent. The following stages involve the older person taking on a "sick" role; learning the behaviors associated with this "sick" role; atrophy of social and personal skills once they are no longer used; and finally a self-identification on the part of the older person as incompetent, sick, useless. At each stage in the SBS there is greater psychological and behavioral dysfunction.

Treatment modes derived from the psychosocial model include behavior therapy and milieu therapy. Behavior therapy is basically behavior modification techniques. Milieu therapy involves creating a structured and supportive environment whereby older persons can relearn living skills in an environment which is both structured for the desired outcome and supportive of learning and positive self-image.

One of the most important concepts your students should understand is that the vast majority of severely disordered elderly are also suffering from chronic disease which are affecting behavioral and psychological functioning. This is especially true with the psychoses.

Although much time has been spent discussing organic brain syndromes, by far the most important mental health problem of the older adult is depression, especially reactive depression. Reactive depression is the result of an important social, personal, or environmental loss. Death of spouse, loss of confidant, poor health, or retirement can all result in depression.

Since older adults are more likely to suffer such losses, they are very susceptible to reactive depression. Depression of this nature is usually easily treated if diagnosed early. Even among the elderly, this form of emotional disorder responds well to therapy, social supports, and if necessary, anti-depressant drugs.

If depression is allowed to go untreated, there is a risk of suicide. In fact, suicide is also a major problem among the elderly. The aged account for a greater proportion of suicides than would be expected on the basis of demography. Among men, there is an almost linear increase in suicide rates with advancing age.

Depression can be treated with any one of several treatment approaches. One primary mode is psychotherapy, counseling, or social interaction, either individually or in a group. Anti-depressant drugs are used together and very good results have generally been achieved.

In addition to the factors already mentioned there are some other purely social factors involved in the mental health of older adults. In general there is a negative relationship between socio-economic status and severe mental illness. This same relationship holds for the aged. The most favored explanation is that the multiple stresses of lower status, such as inadequate diet, housing, medical care, education, family disorganization all combine to increase the rate of psychiatric disability.

Another social factor is marital status. It is very clear that non-married older persons have higher rates of mental illness than married older persons.

Most significantly, the multiple psychosocial stresses of old age play a crucial role in the etiology of mental illness. The most prominent stresses are loss of income, loss of role and status, bereavement, isolation through disability, loss of cognitive functioning. No doubt if enough of these combine in one person the overload could lead to psychiatric difficulties.

UNIT TWO

B. Topic Outline

1. Models of Adult and Geriatric Psychiatry

a. Medical approach (1)* (2)*

1) Focus is on disease aspects

2) Irreversibility of much of behavior decline

3) Drugs as preferred treatment

b. Psychosocial approach (3)*

1) Focus on environmental factors

2) Reversibility of much of behavior decline

3) Behavior and milieu therapy

2. Organic Brain Syndrome

a. Myth of senility

1) Behaviors are not unique to aged

2) Senile psychosis is a disease process

b. Association between physical and psychiatric disability (4)* (5)*

1) 80% of admissions to geriatric psychiatry facilities were moderately to severely physically disabled

2) General physical deterioration

c. Peck's and Alzheimer's diseases (6)*

1) Genetic mechanism

2) Early age of onset

d. Cerebral arteriosclerosis (7)* (8)*

1) Disease not restricted to brain arteries

2) Usually occurs after 70

3) Sudden onset

e. Cerebral vascular insufficiency (9)*

1) Blood supply to brain is inadequate

2) Symptoms may come and go

*Numbers in the outline are keyed to the bibliographic references.

f. Senile brain disease (10)*

1) Cause is not known

2) May be accelerated by normal aging

3. Treatment of Organic Brain Syndrome (11)*

a. Cerebral vascular dilators

b. Psychotropic drugs

c. Anticoagulants

d. Hyperbaric oxygen therapy

e. Reality orientation (12)*

1) Application of behavior modification principles

2) Tailored to individual needs of patients

4. Alternatives to Institutionalization

a. Day care

b. Outpatient services

c. Home care services

5. Social Breakdown Syndrome (13)*

a. Derived from psychosocial model

b. Seven stage negative cycle leading to negative psychological functioning

1) Predisposition or susceptibility

2) Dependence on others for cues to behavior

3) Social labeling as incompetent

4) Taking on a "sick" role

5) Learning behaviors of sick role

6) Atrophy of social and personal skills

7) Self-identification as incompetent and useless

*Numbers in the outline are keyed to the bibliographic references.

UNIT TWO

6. Depression (14)*

   a. Reactive depression

      1) Response to environmental losses

      2) Relatively easy to treat

   b. Endogenous depression

      1) Result of life long pattern and poor psychodynamics

      2) More difficult to treat than reactive depression

   c. Treatment of depression

      1) Antidepressants

      2) Psychotherapy

      3) Electroshock therapy

   d. Suicide

7. Other Social Factors (15)*

   a. Socioeconomic status

      1) Negative relationship between SES and mental illness

      2) Multiple stresses

   b. Marital status

   c. Multiple Psychosocial Stresses

      1) Loss of income

      2) Loss of role and status

      3) Bereavement

      4) Isolation

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UNIT THREE

SOCIAL AND CULTURAL
DIMENSIONS OF AGING

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UNIT THREE

SOCIAL AND CULTURAL
DIMENSIONS OF AGING

I. An Overview of the Sociology of Aging

The major focus of the sociologist is to understand the process of aging within the context of how human groups are structured, how they function, and how they change. Put another way, we ask the question, what is it about the organization and functioning of American society today that has made aging a social problem? Are there some identifiable sets of variables which have contributed to making the phenomenon of aging a social issue? In searching for this answer at the macre-analytic level, we will examine three major areas: (1) demographic characteristics of a population such as their numbers, life spans, literacy levels, etc., (2) social structure - the way in which this population is organized into groups; that is, its institutional ways of organizing such things as work, family relationships, treatment of the sick, etc., (3) the meanings or cultural symbols which persons utilize as an attempt to interpret their worlds. Taken together, we then ask what consequences these macre-level variables have for the individual.

A. Demographic Issues

The problem here is simply stated: In modern societies such as ours there are more people living longer. With decreasing birth rates clearly evident, we increasingly find ourselves with a shifting population pyramid where aged individuals comprise both increasing numbers and an increasing proportion of a population.

This changing population pyramid is not unique to the United States, but is generally a characteristic of the more highly developed nations which have made great advances in increasing longevity among its citizens. For example, the average life expectancy is over 70 years of age for individuals born today in Sweden, Norway, Netherlands, Denmark, France, Canada, Germany, Japan and Israel. By comparison, life expectancy is less than 45 years in less developed nations such as India, Nigeria, Chad, Saudi Arabia, Burma and Afghanistan.

The United Nations predicts that from 1970 to the year 2000 the population of the world will increase by 80%. They expect that the number of older persons aged 60 and over will double. In more developed countries they predict that the aged will comprise nearly 16% of the population, while in less developed countries they will comprise about 7% of the population.

B. Structural Issues

These same factors which have contributed to the extension of the life span have also contributed to structural and cultural changes in other areas of society. The dilemma is that these changes that have brought about the extension of life have also created the conditions that make old age a less than desirable experience. In earlier periods of development most societies are characterized by relatively short life spans, but they are also relatively well equipped to care for their old. Typically, extended family systems of several generations live together in a close-knit proximity. It is a situation where the elderly have children or other family members to help care for them in their later years. In addition to the existence of the extended family, communities are often organized into neighborhoods and religious groups which offer support. But modernization of societies brings about changes in social institutions. Increased education, the developments of modern science, technological breakthroughs, and rising standards of living have not only increased the life span, but they have also altered the basic ways in which we interact with each other in groups.

To put it simply, developed societies have become highly complex and atomized. While people may be living longer, they also tend to live in small nuclear families rather than in large extended family units. The structure of the work force in the society is highly skilled and technological, giving emphasis to the employment of educated young people who enter upon careers which end in mandatory retirements. People in their 30's now find it difficult to enter an occupation because they are too old to begin the career ladder. Additionally, geographic mobility has been made possible, if not necessary, by the growth of large corporations, the need to travel to cities for skilled employment, the mass access to higher education which frees individuals from local bonds, etc. It has been estimated that 20% of the American population changes its residence each year. The result is that large proportions of the population are cut off from the structural ties of extended family and supportive community systems. This breakdown of traditional supportive social institutions in developing nations gives way to formal organizations for meeting social problems, and is frequently a role taken over by government and/or the private sector. Thus, it is not surprising that today institutions and policies regarding the aged are outgrowths of public policy decisions and public incentives for private sector involvement. It must also be kept in mind that modern medical technology has developed to a stage that is best administered in institutions at high cost to the individual consumer, thus increasing the role of the

public sector as well as the private.

We might generalize by saying that in a traditional society the elderly live in their communities with their extended family, usually their grown children. They look after them in their old age and are assisted by the local community groups tied to religious and ethnic solidarities. Increasingly in modern societies the elderly are coming to live alone, with a small group of elderly relatives, or in institutions or retirement settings set aside for that purpose. At one point in time, people desired many children in order to provide for one's old age. Today, the functional equivalents have become retirement annuities, social security, and comprehensive health insurance.

The important point to be recognized in this discussion is that the social institutions which characterize modern societies have become a major problem in attempting to deal with the issue of aging. The problem is not that there are more aged, but that our institutions are still struggling to find ways to appropriately respond. The institutional response to aging is by no means unique. We respond similarly with institutional responses to education, health delivery, work, and nearly all facets of social exchange.

C. Cultural Values and Aging

What are the meanings which a social group attaches to being aged or growing old? Why is it in our society that "being old" is defined as a negative thing? It is here that we turn to the cultural system of a social group, the system of values and meanings which we attach to everyday events. The interesting paradox is to discover that the very values which have created modernization are values which place a negative valence upon growing old. Ours is a value system which stresses achievement, hard work, individualism, technology, change, autonomy, independence, career success, and material comfort. All of these things combine to devalue aging.

The older person who is no longer independent is implicitly, if not explicitly, defined as a drag on the society. The aged come to be perceived as nonproductive and unable to care for themselves. Their knowledge is viewed as outdated. Their families may be scattered, uninterested, lacking in resources, or simply nonexistent. Ours is a society which places such a high value upon individualism and autonomy that neither the young nor the old desire for the aged to become dependent upon the young. It is still a part of our culture that parents will provide for their children; it is

not a part of our culture that the children must later care for their aging parents. This leaves the children free to pursue their own caree s and independence without having to take into account the needs of their parents. Children do not wish to have to take account of their parents' welfare in deciding on a job, a transfer, or a decision to have another child. Aging parents do not want their children to have to take them into account. One needs to ask whether or not it is possible or even desirable to recreate the extended family, or whether we need to concentrate on alternative methods for dealing with the aged. What is clearly needed more than anything is the development of a value system that recognizes the dignity and worth of individuals who have become old. We have written them off too quickly without taking into account their potential for continued contribution to society, continued self-growth, and the rediscovery of their worth and dignity. Many people are becoming sociologically obsolete, long before they are physically unable to perform meaningful social roles.

II. Detailed Review of Instructional Presentations

A. The Family Structure and Processes

All social policy and action programs dealing with the elderly must determine to what degree the family can satisfy the needs of the individual concerned and how much other institutions must take over. Although considerable variation exists in the family in the United States, there are widespread patterns and values which influence policy decisions and support programs for the elderly. Therefore, it is important for your students to understand the structure of the family, the changes over generations and some subcultural variations.

1. The Family and the Value System

Values define our conceptions of the desirable, approved behavior patterns. Although most people cannot always translate their values into everyday life, these conceptions influence our aspirations, our view of life and our level of satisfaction. If there is a great discrepancy between one's values and his or her day-to-day behavior the individual can feel a sense of failure and self-recrimination. For example, if the value of success might be frustrated by lack of education or skills for the job, the individual can either lower his aspirations or feel depressed about his or her own inadequacy.

A good way to begin this section is to ask students to list their important values and those held by the society at large. In the course of the discussion, the following values

should be discussed as they affect the situation of the elderly:

a. Among the most important values is that of individualism and independence. The individual is ideally viewed as free to place his or her own needs and desires above that of the primary group. As this value is translated into actual choices, as it affects the elderly, it means that in the hierarchy of important relationships, the individual comes first, while the parents' needs are satisfied only after the occupational or personal needs. While independence is strongly adhered to, dependence of any kind is a negative social characteristic. Consequently the inevitable physical, economic and social dependency which characterizes most older people demeans them in their own and other's eyes.

b. Accent upon youth as the desirable age category means that old age is essentially an undesirable category. Every culture selects certain times of life which receive greater rewards, esteem and higher social status. The United States has always been future oriented where sources of innovation, knowledge and values have been defined by the younger rather than the older generation.

2. Configuration of the American Family

The values discussed above should be put in the perspective of our dominant family patterns, or more specifically, in the configurations most frequently found. These configurations can be determined through class discussion by encouraging the students to identify more specific conceptions of the desirable family goals. Then, relate these configurations to the effect they have on the older people in our society. Topics discussed should include the following:

a. Marriage is a dominant life goal defined as the most important relationship. Effect -- obligation to one's spouse takes precedence to one's parents.

b. The new household or place of residence is not determined by either spouse's family or origin. Effect -- more and more households are geographically removed from older parents.

c. Declining authority of old over young. Effect -- the participation of elderly parents in decision-making or daily affairs of the family is minimal.

d. Related nuclear families are bound together by affection and choice. Effect -- since kinship support is not obligatory and can be utilized only on an optional basis, one cannot always be certain of assistance from kin.

e. Instrumental goals, in terms of occupational success, should be pursued at the expense of any obligations to parents. Effect -- parents should never interfere with job opportunities of their children.

f. The family is bilateral in structure in that neither wife's nor the husband's family is more important. Effect -- with no clear definition of who is responsible to the parents, all children share it, and essentially no one shares it.

g. The privacy of the nuclear family is both desired and respected. Effect -- one must never intrude and be a burden to one's children by destroying their privacy.

3. The Structure of the American Family

Most individuals live in nuclear families, which are composed of husband, wife and immature offspring. These households are economically independent and residentially isolated from the kinship group. This nucleated pattern is also evident when you examine the types of household arrangements for individuals over 65. Options in living arrangements can be viewed in terms of two variables: the degree of dependence or independence, and the degree of isolation or integration with others.

Independence

I	II
Old living in isolated nuclear household or alone	Married elderly couple living in classical extended family of three generations
---	---
79% of the married 48% of the single, widowed or divorced	2% live with married children, grandchildren

Isolation----------Integration

III	IV
Old living in institutions	Widowed parent living with one child as incapacity increases
---	---
3.7%	14% live with married child 18% live with unmarried child

Dependence

(Shanas et al.)

Research indicates that the Type I living arrangement is by far the most common choice in the United States for both married couples and single individuals. The second most frequent arrangement is Type IV choice in which a widowed parent moves in with a child, most frequently an unmarried one, as he or she becomes incapacitated. Institutional living, Type III, or the three generation family, Type II, rarely are used. These figures reflect the dominant household. They also indicate a process of age segregation operating as opposed to age integration.

Discuss the implications of these findings, having your students determine the best kinds of housing and the desirable

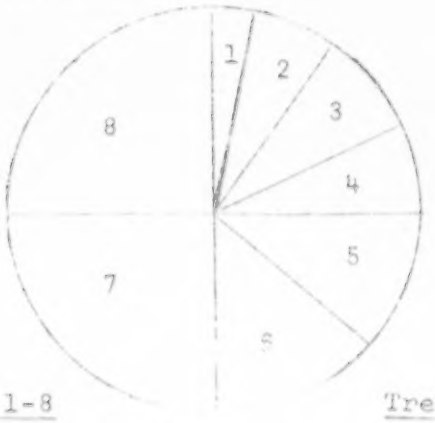
community support patterns for the elderly given the dominant residence patterns.

4. The Developmental Cycle of the Family

The stages a family passes through, the births of children, childrearing, the education and launching of teenagers, generally proceed in an orderly sequence. However, the age of marriage, the spacing of children, and the numbers of years devoted to these developmental tasks change over time and from country to country. Using the following chart, have your students examine this spacing of important life events and determine its impact on those individuals in the last two stages of the family cycle.

In your discussion, emphasize the important changes which have essentially resulted in a quickening of the family cycle and a telescoping of the major function of the family, that of childrearing, into fewer and fewer years. This condensation has taken place at the time of increased longevity. The result is a family cycle in which one-half of its length is characterized by limited functions. The married couple in early middle age have launched their children and look forward to a declining participation in their children's lives. Such processes like others we have discussed lead to an increased emphasis on the marriage and some attenuation of the parent-child tie.

DEVELOPMENTAL CYCLE OF FAMILY



Years in Stages 1-8

1. Marriage without children- 2 years
2. Childbearing families- 2.5 years

Trends over 3 Generations

1. Marriage at earlier ages
2. Fewer children born
3. Voluntary child spacing

Years in Stages 1 - 8

1. Marriage without children - 2 years
2. Childbearing families - 2.5 years
3. Families with preschool children - 3.5 years
4. Families with school children - 7 years
5. Families with teenagers - 7 years
6. Families as launching centers - 8 years
7. Middle-aged parents, empty nest to retirement - 15+ years
8. Aging family members, retirement to death - 10-15 years

Trends over 3 Generations

1. Marriage at earlier ages
2. Fewer children born
3. Voluntary child spacing
4. Children spaced more closely
5. Grown children launched earlier
6. Launching stage shorter
7. Periods of child rearing shorter
8. Earlier empty nest
9. Longer time together without children
10. More years after retirement
11. Longer life span
12. Larger number of older relatives

5. Patterns of Interaction of Elderly Americans

This area of research demands consideration by those working with older people. Although society operates on the assumption that the family can provide little security, large scale research finds older parents are not as isolated as usually believed. Most of the research, however, documents numbers of contacts rather than examining, for example, whether these contacts arise out of burdensome obligations or genuine compatibility and mutuality. After presenting the findings to your students, discuss the possible quality of interaction with children and its rewards to the elderly parents.

a. Family Support Systems

Although the elderly are not generally incorporated into the extended family household, extensive research on the family of older people has found that the family remains the primary source of support for most individuals.

Having children remains the major form of old age insurance available in the United States (Shanas, 1973).

1. Four out of five have at least one living child.
2. 79% live in a separate household from their children.
3. 61% live either in the same household or within ten minutes from one child.
4. Of those not living with a child, 52% saw one child within the past 24 hours while 78% saw one child within the past week.
5. At least 34% of the older men and 43% of the women saw a brother or sister within the past week.

b. The Parent-Child Relationship

Although living separately from children does not mean isolation to most people, more needs to be known about the quality of interaction with children and to what degree this contact is a source of high morale. The American kinship system is sometimes described as portraying intimacy at a distance where the integrity of marriage is respected to the degree that social distance is scrupulously observed. Clark and Anderson best summarize the situation in the following terms, but it is important to remember that this varies considerably by a family's social class and ethnicity.

1. A good relationship with children in old age depends upon the autonomy and independence of the parents.
2. When older parents can function independently physically, economically, and socially, the relationship is maintained without conflict.
3. When the parents' resources fail, conflicts and strain arise in the relationship.
4. Strains can be traced to excessive dependence and also to attitudes and values.

c. Grandparent-Grandchild Relationship

This tie is not generally one of continuous interaction, for the generation gap becomes doubly magnified.

The most satisfying period for the grandparent is when the grandchildren are small. However, the phasing of the life cycle places this stage in middle age, not during the more leisurely retirement phase. During old age, grandchildren are usually in adolescence or early adulthood when conflicting values become even more prominent.

d. Husband-Wife Relationship

Studies have shown that marriage, like old wine, improves with age. The relationship becomes more egalitarian and is characterized by a greater sharing of activities and interests. The problem here is the sex differential mortality rate which results in widowhood and the absence of marital supports for most older women.

e. Friends and Neighbors

Friends are an important source of sociability for many older people, and are particularly important among those of higher socio-economic status. Since these friendships are generally made in middle age among those the same age, most report a decline in the number of friends over the years due to death and geographic mobility. Most also report some difficulty in replacing friends that die, due to reduced economic circumstances, limited mobility and increased disability. A reversal of this trend might be found in the increased movement into age-segregated communities where spontaneous primary relationships develop (see Part IV). The old who live among other old people make more friends than those who live among young people and consistently show higher morale.

The increased segregation by age can be justified by these findings of higher morale among those who live among age peers. Whether this is second choice because expectations from children are not met is unclear and worthy of discussion among your students. Some critics condemn this pattern of segregation as a justification of present values rather than a decision of what's best for the elderly. Nevertheless, the rewards found in contacts with friends of one's own age are significantly high so that any social planners should consider it in their decision-making processes.

B. Actual and Potential Role Changes Available to Persons in Later Life

1. Role Exits

Roles are our structured mode of participation in social life. Throughout our lives, we all play numerous roles, which are structured by society and define our personal and social identity. As an individual matures, he or she moves from the major roles of son or daughter and student to that of the work role and the marital role. Although he maintains some kinship and friendship roles, social processes facilitate exits from old roles and entrance into new roles. For example, the marriage ceremony or the graduation exercise signifies a transition from family dependency into independent adulthood.

As an individual approaches sixty-five, he or she looks forward to major role exits: generally for the males, they exit from occupational roles; for many females, they exit from marital roles and enter widowhood.

a. Occupational Roles

Only 32% of the men over 65 years in the United States remain in the labor force, and this percentage is expected to decline rapidly in the immediate future. The problems of retirement can be viewed as a relatively recent phenomenon, for in 1900, 68% of American men over 65 remained in the work force. On the other hand, the percentage of older women in the work force has remained relatively constant over this period.

b. Marital Roles

Widowhood is essentially a problem for women as the figures illustrate:

Percentages widowed (1960)

	65-69	70-74	75-79	80-84	85+	Total Age 65+
Men	10.2	16.8	25.3	37.2	52.8	19.1
Women	37.9	50.4	62.2	73.1	81.4	52.1

Discussion:

When the situation of the elderly is viewed in terms of role exit and role loss, one can see that solutions to the problem involve the processes of role restitution: the substitution of new roles to replace those important

roles which have been lost in the inevitable progression of the life cycle.

2. Life Space of the Elderly

List the major categories of roles; then determine a count of the roles the average older person occupies and the frequency that he or she might perform the roles. This count determines Life Space of an individual.

Roles	Occupied	Frequency - daily, weekly, monthly
Spouse		
Parent		
Grandparent		
Kin		
Friend		
Neighbor		
Voluntary Organization (Church, Club, Etc.)		
Worker		

The life space measurements based on the number of roles performed indicates the degree of disengagement an individual has experienced. As individuals approach old age, their life space generally shrinks as they relinquish marital and occupational roles. Even though the opportunity for voluntary roles increases with the increase in leisure time, all too often problems in participating arise. Physical disability, transportation problems, and attrition of friends through death prevent active participation. These factors have led gerontologists to consider and debate the controversial theory of disengagement.

3. The Theory of Disengagement (Cumming & Henry)

Before considering the processes of disengagement, certain points must be made. This theory is controversial, because its critics interpret it largely in negative terms -- that an individual becomes isolated because he or she disengages from life's major roles. Although this is true in some situations, such isolation probably applies to only a small minority of older people. In addition, an important determinant of the degree of disengagement is the psychological pattern of the individual, which is not always related to age. (See Psychology Unit.) Consequently you should stress the positive features of disengagement, i.e., an individual is given the "permission"

to disengage from some roles, like the occupational. This withdrawal does not necessarily have a negative effect; in fact, it can free the individual to pursue long-delayed interests and the development of new friendships. One can also concentrate on important intimate relationships within the family as he or she withdraws from peripheral relationships. With these distinctions in mind, you can emphasize both the positive and negative aspects of disengagement.

a. Beginning in middle age and accelerating around retirement, there is a process of mutual withdrawal between the aged and society. This process, which can be initiated by the individual or society, comes with the shift from future oriented goals to present oriented interests. Disengagement is accelerated when losses begin to outrun replacements such as the loss of a friend or when a child moves away.

b. Disengagement involves the abandonment of life's central roles; retirement for the man; widowhood for the woman. Men generally face a more radical shift from the work role to the retirement role. Women, on the other hand, continue to play familial roles of parent and grandparent after they leave the marital role.

c. Disengagement can be the result of obsolescence or the decrement of knowledge and skills, or it can be the result of a change in the individual's motivation.

d. With the reduction in social interaction, an individual is increasingly freed from normative controls and from the usual social obligations. For example, evidence for this is the growing eccentricity of some old people.

e. In old age, roles shift from vertical relationships to horizontal. This essentially means that individuals move from age-integrated contacts spanning generations to age-segregated contacts with others predominantly their same age.

Evidence:

a. Individuals are forcibly disengaged with mandatory retirement from work roles. This role exit causes disengagement in auxiliary roles such as friendships and organizational roles related to work.

b. Several styles of aging are possible depending upon

individual personality characteristics. Some individuals experience a life long process of disengagement which is not specifically related to age. Others can avoid the shrinkage of life space by changing forms of participation rather than reducing the total number.

c. With the decrease in activitiy, research shows a decline in morale and contentment. However, the desire to stay active and involved is generally accompanied by the desire to withdraw from some commitments in order to have more time for leisure, hobbies and contemplation.

Discuss the implications of disengagement and the needed processes of re-engagement through new roles for the aged. (Consult Unit 6, section D, New Roles for the Aged, for topics to consider.)

4. Activity Theory and Role Restitution

This theory is a statement of popular beliefs -- that one must keep active, and stay busy. Inactivity is viewed as bad for the individual and leads to depression, low morale and even illness. Consequently, the elderly should continue those activities of middle age as much as health and energy permit. These goals can be expressed in the section on New Roles for the Aged (6-D). One problem with application of this theory is the creation of genuinely useful activities for the elderly and the avoidance of idle "busy work." Ask your students to suggest useful programs for this purpose.

C. Life Style Adjustment of Older Americans and Age Related Changes in Social Functioning

1. Morale

Although research does point to some isolation and disengagement of the elderly, it also identified some sources of high or low morale (Clark and Anderson):

Sources of High Morale (Rank Order)

a. Entertainment and diversion

b. Adequate socializing

c. Productive activity

d. Physical comfort

e. Financial security

f. Mobility and movement

g. Health, stamina and survival

Sources of Low Morale (Rank Order)

a. Dependency -- financial and physical

b. Physical discomfort and sensory loss

c. Loneliness, bereavement and loss of nurturance

d. Boredom, inactivity, immobility and confinement

e. Mental discomfort or loss

f. Loss of prestige or respect

g. Fear of dying

h. Problems of others

Discussion:

Using these factors as a guide, identify those sources which can be utilized in action programs designed to improve the status of the elderly.

2. New Communities for the Aged

Some research has found that old people living among their age peers are less likely to disengage from social ties. If they are with people like themselves, friendships are easily formed and maintained, and the activity level remains high.

a. Retirement villages

About 10% of the elderly live in age-segregated communities which exclude younger families with children. These villages like Sun City and Leisure World are more prominent in warm areas of the country where outdoor recreation is important. (Sheila Johnson, "Growing Old Alone Together." New York Times Magazine). Because of the high cost involved, this option is open only to the relatively affluent older person. Residents also must be physically healthy and active.

b. Age segregated housing developments with high social integration

Hochschild's The Unexpected Community describes a small apartment building where family-like ties develop among the residents. This is a readable, interesting account which describes the process in the formation of an intimate community.

Other residential options include residential hotels or life-care institutions. The issues for discussion have been reviewed in Section A.5.e and essentially involve the age-segregated versus age-integrated housing. Have your students discuss the advantages and disadvantages of each.

D. Describe and Understand the Nature and Causes of Intergenerational Conflicts That Exist Between the Elderly and the Young

All societies face the problem of training young members to eventually fill important positions as they are vacated by the death or disability of older members. In preindustrial societies with a slow rate of change, the replacement is an orderly, cyclical process. One is born and gradually over the years is socialized into the roles of adulthood. He learns to hunt or grow grain, he participates in a puberty rite signifying his maturity, he marries and enters adult economic and political roles, and he has children of his own. If few new elements are introduced into the culture, his children will be socialized in much the same manner with the same set of expectations of adult roles. The gap between father and son will be small, because the only differentiation is that of age.

When social change accelerates, the hiatus between generations widens. Each parent is a product of his or her own socialization, so the point of view between parent and child is usually wide. Conflict is inherent despite attempts parents might make to catch up with a child's point of view. The problem becomes magnified with immigrant or socially mobile families, because the two generations are essentially living in two subcultures. These factors are particularly prominent in the United States not only because of rapid social change but also because there are many groups competing with parental authority. The school system and peer group define norms which can be in opposition to parental attitudes and ways of doing things. To understand how this discrepancy can affect large numbers of the population, the following statistics are relevant:

1. Twenty per cent of the population are foreign born

and another 18% are children of one or both parents of foreign ancestry.

2. Educational differences of persons over 65 years of age are wide; the median years of schooling is 8.4 as compared to 11.7 for the total adult population.

3. The old today were born before the massive moves to urban areas, so older parents could well have been born in more isolated rural areas where they were less exposed to the heterogeneity of the city.

4. In sum, value differences between generations are quite prominent in the United States. Conflicts can easily arise over life style differences in drinking, smoking, sexual mores or etiquette. In addition, conflicting views in such important values as religion, childrearing, or male-female roles can interfere with the harmony between grandparent, parents and children.

Richard Kalish has described a prototype of vastly different generational experiences which is a useful source of class discussion (pp.49-50).

> The father was born in 1898; as a child he had no telephone, movies, airplanes, automobiles, running water, or -- very likely -- electricity. His country was not a world leader, had no race problem it was aware of, had no income tax or Social Security, and was not cognizant of having urban problems. Most likely Father was from the farm or a small town, raised Protestant, knew no Jews and few Catholics, and had never considered the possibility of a black man as a peer. After finishing ninth grade, he went to work, just in time to enter the armed forces for World War I. At 22, mustered out, he re-entered the work force, married, had children, bought insurance, and eventually voted for a chicken in every pot. At the age of 31, with two small children and vocational skills developed on the job, the stock market crash wiped out the investment money he had been speculating with, perhaps forced him to lose his insurance policies, and scared the hell out of him. At 35, the world caved in, and he was jobless, with a 15-year-old and a 10-year-old to take care of. Giving him the benefit of the doubt, let's assume he quickly landed another job, and that he managed to keep his family going, although it was pretty much hand-to-mouth for a while. In his early forties, he left his job for war industry and, for the first time, was covered by Social Security. However, in spite of a few good years, he was tossed back into the

job market at the age of 47, without salable skills. He did get another job, or perhaps remained with his previous company at somewhat reduced status, hung onto the low-paying job, and managed to retire in 1963 with a modest amount of Social Security, a small house with the mortgage nearly paid up, a married daughter and a son with two years completed at State University whose starting salary on his initial job nearly equaled his father's highest salary. Now he hears talk of urban renewal, ecological disasters, negative income tax, Black Power, sexual equality, communal living. The entire value system he felt comfortable with seems distressingly challenged.

The son has had a much different life. Still a child during the Depression, he has some vivid images and remembers that his family had very little money to spend. He recalls being urged to get an education so that he could obtain a good job and never be unemployed, and he was pushed to do well in school. He went into the armed service just in time to catch the GI Bill, and he spent two years in college before dropping out to take a job. His life has been a series of steps up the economic ladder, and it seems logical to him that study and hard work should do for everyone what it did for him. After all, his father was poor and uneducated, but made the necessary sacrifices to do a good job of raising two kids. So Son works, achieves, purchases, buys on credit, improves his housing and his automobiles, and decides that his children will go to the best college possible and will move up even higher. He has worked hard to earn what he now enjoys and, although fleeting images of Depression days occasionally disturb him, he feels as secure as his credit payments and health permit. Although not a churchgoer, he has internalized many of his father's traditional Protestant beliefs, and he expects his children to do so also.

The third generation you all know. But, as I described Generations I and II, I might have been describing the backgrounds of two social-class groups or two ethnic groups. Today we are so alert to social-class and ethnic differences in values that it seems strikingly naive to ignore the fact that age-cohort differences have the same impact (Kalish, 1969a).*

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*From Kalish, R.A. The old and the new as generation gap allies. The Gerontologist, 1969, 9(2), pp.83-89. Reprinted by permission.

E. Cross-Cultural and Subcultural Variations in the Characteristics, Needs and Resources of the Elderly

1. A Cross-Cultural Perspective

Throughout this discussion, we have dealt with those factors in our society which create considerable problems for the elderly. Therefore it is useful to examine other cultures in order to see in clearer relief the sources of strain in our society. One pervasive point has been our value system which extolls individualism and independence. To introduce this section, read Kalish's vignettes which contrast our country with Japan.

> An American mother in snug-fitting pedal pushers, her hair in curlers, is walking rapidly through a chrome supermarket. Behind her, trotting to catch up and trying to clutch some symbol of her physical presence, is her two-and-a-half-year-old son. The mother speaks: "Fa Chrissakes, Robert, what kinda kid are ya, always hanging on to yuh mother's apron strings?"
>
> A Japanese mother in a loose, plain housedress is walking slowly past the stalls of a crowded Tokyo shopping arcade. On her back, slung from a padded obi, her two-and-a-half-year-old son wriggles for freedom. The mother turns her head: "Abunai, abunai, danger, careful! Please remain quiet until we return home."
>
> An American politician is orating: "...and every American deserves the right to individualism, freedom, and happiness." His audience cheers.
>
> A Japanese politician is orating: "...and every son should remember his responsibility to his emperor and country, and his filial obedience." His audience cheers.
>
> A middle-aged American woman says to her husband: "I don't see why your mother can't take care of herself. After all, she's got social security, and you and your brothers could chip in a little each month and get her a room someplace."
>
> A middle-aged Japanese woman says to her husband..... The truth is she probably would not say anything, because in spite of any reluctance on her part to care for her in-laws she has internalized the value of submissiveness. In addition, she recognizes her vested interest in keeping the status quo to assure her own old age security in a society where family obligations to the elderly are

changing as rapidly as in ours -- perhaps more rapidly.

An elderly American woman sits in her hospital bed and talks to her roommate. "Well, now, I've always believed that old folks shouldn't be a burden to young people, because young people need to have their happiness and independence. I don't know what I'll do when I get out of here -- maybe I'll try to get into a nursing home. I want my independence, too."

An elderly Japanese woman says to her hospital roommate: "When I leave here, I will live with my eldest son and his wife. My daughter-in-law is not happy about this, but her happiness is not so important just now."

These scenes indicate how in Japan dependency rather than independence is incorporated into every phase of the life cycle, so that as the individual approaches old age, his or her impending dependency can be readily incorporated into family functioning. At the opposite extreme, in the United States, the inevitable dependency of the old becomes a social problem to which the family cannot accommodate. Hence, rather than seeking solutions within the family, our country uses governmental and community organizations to solve these pressing problems.

The second example is that of the Igbo, an African culture which is still relatively untouched by the modern industrial world. (Shelton in Kalish, 1969). Shelton finds that among these people psychosenility is quite rare. He identifies the source in the high status of the elders. The old are identified by a cluster of positive items such as "wise," "skilled," and "those who rule." Becoming old means one enters the most desirable social category. They become members of the leisure class who receive the most privileges and respect.

Since the Igbo religion involves ancestor worship, the elders are the closest spiritually to the ancestors. In the role of intermediaries between the ancestors and the younger members, they exercise great control over the life and destiny of all.

In addition, the Igbo, like other cultures without a written language, must use the elderly as repositories of knowledge, rituals, medicinal lore, and history. As interpreters of the culture and sources of its transmission, the status of the elderly is greatly enhanced.

(For other cross-cultural examples, use Cowgill & Holmes, Aging and Modernization.)

Summary of Cross-Cultural Contrasts

The position of the aged is higher and more valued in those cultures with the following characteristics:

a. Preliterate and preindustrial societies with a minimum of specialization.

b. Societies in which power resides in the aged either through the control of wealth and property or spiritual values (such as ancestor worship).

c. Societies experiencing a slow rate of change.

d. Societies with stability of residence.

e. Societies which provide the old with useful roles to perform.

f. Societies which have an extended family system and an interdependent cooperative network.

A review of the position of the elderly indicates that in contrast to the majority of the cultures of the world, the United States has numerous characteristics which are inimical to a high, esteemed position of the elderly. (Rapid social change, advanced technology with specialized division of labor, individualistic religious values, social and geographic mobility, arbitrary definition of old age and retirement at 65, and a nuclear family form.) These factors should be considered in any discussion of programs to improve their position.

2. Ethnic, Racial and Socio-Economic Variations

Although most topics in gerontology need additional research in order to enact service programs, the area of cultural differences suffers the most from the paucity of systematic research. Very little is known on the variation in adjustments to aging among racial and ethnic minority groups. Furthermore, the literature is unclear in indicating whether their status is a result of lower social class or their minority group membership. In addition, minority groups are frequently treated holistically so that social class and urban-rural variations are obscured. Middle-class models are also frequently used to measure the situation of all individuals. Information on Aging Black Americans indicates the problems in this area.

a. Characteristics of Blacks over 65:

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1. The Blacks have a relatively young population with 44.7% being under 18 years of age. While 10% of the white population is over 65, only 6% of the Blacks are (although they comprise 12% of the total population). This discrepancy is due to both a high birth rate and a shorter life expectancy among Blacks.

2. The distribution of the Blacks throughout the country is skewed with 52% living in the South, 22% in the North Central states, 18% in the Northeast and 8% in the West. Hence, Blacks are concentrated in areas where social services for the aged are least developed.

3. The Black male over 65 has only slightly more than one-half the median of his white counterpart -- $1,470 in comparison to $2,788. Among white males over 65, 32.8% have annual incomes under $2,000, while among Black males over 65, 61% fall into this category. Over 90% of the aged Black females have incomes less than $2,000 in comparison to 78% of the aged white females. The median income for Black women over 65 is $1,005.

4. Poor housing is another problem for the aged Blacks. 29% live in dilapidated housing, as compared to 8% of the whites.

5. While all aged have less education than the younger generation, the problem is more serious with the Blacks: the median education level is 6.1 years for Blacks in the 65-74 year old group in comparison to 8.9 years for whites.

Despite this grim view of the socio-economic status of older Blacks, some research indicates a higher level of social integration for older Blacks which has eluded many whites. One study found that two-thirds of the Blacks in comparison to one-third of the whites were "engaged" rather than "disengaged." Hence they tended to have a higher level of social activity and relatedness to others. Another study found that older Blacks have a higher level of religious activity.

One tentative conclusion can be reached on the basis of a scattered research which has important implications for all aged Americans. When a family faces economic hardships, they become merged into a

more interdependent group where the assistance of all members is required. Consequently, elderly grandparents are more likely to be assigned useful roles to play. If that is not possible due to physical disability, their Social Security check might well make the difference between borderline survival and decent meals for all family members.

b. Some comments on other minority groups can be made even with the problem of little research. Such groups as Mexican American or Oriental Americans have generally brought with them to this country more highly integrated family systems which provide greater security supports for elderly family members. For example, the Oriental Americans have a family system which has its origin in a value system stressing group oriented goals over individualistic ones. Their immigrant parents and grandparents placed a great deal of stress on the authority of the parents and respect for elders. Whether these values and behaviors will be resistant to assimilation is one of the most intriguing research questions today. Does movement into middle-class occupational groups with greater wealth and freedom also enact changes in the family system? If so, does this success take place at the expense of older family members who then must seek nonfamilial forms of support?

3. Social Class Variations

Most research has shown that higher socioeconomic status is consistently related to higher morale among older Americans. Adequate retirement income facilitates independence, travel, and other pursuits of leisure interests. Such independence is compatible with cultural expectations held by the aged, their children, and the society at large. Any change to a lower economic status not only affects the self esteem of the individual concerned but also the relationship with offspring.

Although middle-class retirees with more resources generally fare better in morale measures, they also have had a more nucleated family form and live a greater distance from their children than have their blue-collar counterparts. Blue-collar families are more likely to be more actively involved in extended family activities and mutual support systems with their children. However, one researcher found that those elderly who have high expectations of support from their children, irrespective of social class, have lower morale, because these expectations all too often meet with disappointment. The implications of these factors point to

the importance of economic and emotional independence at all class levels for contentment in old age.

4. Urban-Rural Variations

During this century the rapid urbanization has affected all age levels; 70% of those over 65 are urban, which is the same percentage as the general population. However, because of the high geographic mobility, older people are over represented in the inner city, while their children move to the suburbs. Smaller cities and some rural areas also have more older people as the young seek greater opportunities elsewhere. The effect of this mobility can only mean a trend toward the breakup of the more intimate and continuous intergenerational relationships of old neighborhoods. More importantly, increased mobility frequently leaves the elderly somewhat isolated from their adult children. The nostalgic view of rural America, the family farm with all generations living in harmony, each with a useful role to play, was probably more myth than fact. Nevertheless, the great movements of our population have inevitably led to increasing segregation of the elderly from the younger generation.

III. SUGGESTED INSTRUCTIONAL OBJECTIVES

A. Cognitive Objectives

The student will be able to:

1. Describe actual and potential roles and role changes available to persons in later years of the life cycle.

2. Assess the impact on needs and characteristics of the elderly of economics, social forces, cultural value systems, and social institutions.

3. Describe major variations in the characteristics, needs, and resources of ethnic, cultural and geographic subpopulations of the elderly.

4. Describe and understand the nature and causes of intergenerational conflicts that exist between the elderly and the young.

B. Affective Objectives

1. An awareness of his (and others) culturally based views of aging and older persons.

2. An awareness of the relationship among age-linked attitudes and basic cultural values concerning,

e.g., old/new, modern/traditional.

C. Behavioral Objectives

1. An ability to find and utilize basic literature in gerontology.

2. A beginning ability to formulate appropriate matchings between the complex needs of older persons and suitable needs-meeting environments and programs.

Note: Further objectives may need to be specified for your particular situation.

IV. OUTLINE OF SPECIFIC TOPICS AND SUB-TOPICS

A. Family Structure and Processes
   1. The Family and the Value System
   2. Configurations of the American Family
   3. The Structure of the American Family
   4. Developmental Cycle of the Family
   5. Patterns of Interaction of Elderly Americans
      a. Family social support systems
      b. Parent-child relationships
      c. Grandparent-grandchild relationship
      d. Husband-wife relationship
      e. Friends and neighbors

B. Actual and Potential Role Changes in Later Life
   1. Role Exits: Widowhood and Retirement
   2. The Life Space of the Elderly
   3. The Theory of Disengagement
   4. Activity Theory and Role Restitution

C. Life Style Adjustments of Older Americans and Age-Related Changes in Social Functioning
   1. Morale and Adjustment Styles
   2. New Communities for the Aged

D. Intergenerational Conflicts

UNIT THREE

E. Cross-Cultural and Subcultural Variations in the Characteristics, Needs and Resources of the Elderly

1. Cross-Cultural Perspective
2. Ethnic and Racial Variations
3. Social Class
4. Urban-Rural Trends

V. INSTRUCTIONAL STRATEGIES

A. Films

1. "Peege"
2. "To Live Until You Die"
3. "Four Grandmothers"
4. "You'll Get Yours When You're 65"

B. Class Discussions

Use Situational Analysis: resolution of dilemmas presented, e.g.:

Suppose a family has had the wife's mother living with them for 10 years. It always worked out well while the children were young, for she was a great help. Now she is less active and has become irritable with the teenage children's loud music and frequent visitors. Since she causes so much conflict, the husband thinks she should move out. He says his wife must choose between her mother and her children. The wife says she could never do that, for then she would be rejecting her mother. What do you think they should do?

Mr. and Mrs. Smith are arguing over Mr. Smith's mother. He wants to buy her a new T.V. set but his wife says they cannot afford this. She told Mr. Smith he should think of his own family first. Mr. Smith replied that he could have another wife and children but never another mother. What do you think of this situation?

C. Life History

1. Interview an older member of your community

Examine roles occupied -- etc.

Quality of relations with children, grandchildren, etc.

Examination of past life

Morale

2. Write a description of one's own family

   Focus on grandparents, parents, and child relationships

   See what changes have taken place in:

   a. Values (attitudes toward sex, drinking, permissiveness, etc.)

   b. Social status (mobility, education, occupation)

   c. Family size and concentration of kin (as affected by geographic mobility)

   d. Ethnic - if relevant - speed of assimilation

3. Assign some participant observation in housing developments or other community settlements in order to investigate the formation of social ties among older people which substitute or replace those lost through death or mobility. Determine what activities act to facilitate the engagement of residents, who participates (males-females), and what kind of leadership encourages this sociability.

VI. EVALUATION STRATEGIES

Depending on your particular students and instructional situation, either the affective or cognitive objectives may be judged as more important. However, in this unit, the achievement of either set can be evaluated in relatively similar ways. The subject matter readily lends itself to a project-based evaluation system. Some suggestions follow:

- Student reviews/critiques/analyses of selected books, plays or television shows. The students' work would be judged on its analysis of how the particular piece illuminates cultural forces and their impact upon the elderly.

- Student-conducted demographic research on the local area. Students could be provided with some basic research techniques and data sources and asked to derive some conclusions regarding the cultural forces operating on the aged of the community. These projects could be methodologically simple, but they would force students to take a close look at the community. Evaluation of student efforts could be based on their identification/justification of cultural forces.

- Comparative analyses of documents, stories, or other

artifacts from cultures whose treatment of the aged is different from our own. Evaluation criteria could focus on student ability to identify cultural forces and draw inferences for our own culture.

More objective measurement activities could be developed including traditional tests and attitude scales. Use of such "paper and pencil" exercises would be justified if you were concerned with student achievement in highly specific areas.

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UNIT FOUR

ECONOMICS OF AGING

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UNIT FOUR

ECONOMICS OF AGING

I. Introduction and Topic Overview

Economics is closely tied to other content areas and should be studied in conjunction with the rest of the units in the course. This unit should provide a basic overview on the topics of employment opportunities for the aging, income maintenance programs, and retirement. There is a wealth of literature available on these topics and the issues surrounding them. This unit selects a few of these resources, and these, along with the suggested instructional methods, should enable students to conceptualize the economic realities of old age. Most importantly, this unit should increase the student's empathy for older persons under today's system and help them grasp the impact of economic factors on their own aging process.

A. Employment Opportunities for the Aging

A study of employment opportunities should begin with those already in the labor force who are approaching retirement; the forty-five to fifty-five year old worker who may be experiencing increased problems holding his job or finding employment. The issues involved here often reflect questions of civil rights, and students should become aware of laws and programs which protect and benefit the older worker.

B. Income Maintenance

"There is no substitute for income if people are to be free to exercise choices in their style of living." This is the opinion expressed by delegates to the White House Conference on Aging as part of the preamble to their recommendations. The importance of an adequate income cannot be overstressed, and students of this course should be able to examine the systems provided to maintain adequate income levels for the aging. Social Security along with SSI, pensions and other programs aimed at retirement security for the aging must be identified and examined. Compared to these sources of income, the student should explore expenditure patterns and basic costs involved in "making ends meet," with special emphasis on health care needs and expenses. The basic premise of this section is that retirement income systems fall short of adequately meeting the needs of older persons. Specifically, retirement income levels average one-half of the person's previous income while the needs of older people do not drop, and may increase due to health factors. Identifying the gaps in income maintenance systems, and exploring the major proposals for reform should increase the students' sensitivity to the problems.

C. Retirement

This section will cover the range of variables affecting the process of retirement and post-retirement years. In addition to reduced income, topics should be explored such as the loss of social roles, friendship contacts and various activities. Attention should be given to alternatives for the utilization of increased leisure time in areas such as creative work, part-time employment or volunteerism.

Retirement is, for most people, a crisis period....one that calls for increased support systems to carry the individual through the transition period from work to retirement activities. This unit should emphasize pre-retirement programs and their economic requirements and benefits. This unit will also explore the problem of poverty among the aging. It should point out the detrimental effects of an inflationary economy on the older person and the causal role played by economic forces in critical life decisions: to maintain a house or move to smaller quarters; to take up residence with a son or daughter, etc. Unfortunately, many of these topics cannot receive an in-depth treatment within the scope of this course.

II. Suggested Instructional Objectives

A. Affective Objectives

Students studying this unit should begin to develop:

1. An awareness of societal attitudes linking the worth of the individual to productivity.

2. A respect for the aged as a valuable human resource.

3. An appreciation of implications of work and retirement on the individual in terms of reduction of income, loss of roles, societal disengagement.

4. An awareness of the fact that volunteerism may mean expecting older persons to volunteer their time for work that others are paid for.

5. An awareness that present income maintenance systems in retirement fall short of adequately meeting needs.

6. An insight into the vulnerability of the aging with regard to economic conditions and to poverty.

7. A belief that there is a critical need for reform in the area of income maintenance, labor and retirement practices.

B. Cognitive Objectives

After completing this unit, students should be able to:

1. Identify the major sources and levels of income of the aging population.

2. Describe the intent and purpose of the Social Security Act of 1935 and the Supplemental Security Income Amendments.

3. Demonstrate a factual knowledge of how changing labor force practices, economic conditions and age structure of the population have affected the original intent of the Social Security Act and, in turn, the role and status of the older person.

4. Enumerate major proposals for reform of the Social Security Act.

5. Describe the advantages and disadvantages of different income maintenance/income security mechanisms.

6. Describe the opportunities for employment of the older person and the barriers to participation in the labor force due to age discrimination and retirement practices.

7. Describe the major provisions of pension plans, understand their inadequacies, and assess the proposals for reform of pension systems.

8. Enumerate the major expenditures of the older person.

9. Describe the major impacts of retirement including reduced income and role losses.

10. Identify and describe the nature of poverty among the aging; its causes, its implications for the individual, andits possible remedies.

11. Identify major programs which create volunteer opportunities for the aging.

Note: These are suggested objectives, and there may be others specific to a given situation. In addition, it may be advisable to emphasize certain objectives in response to student needs and instructional resources. As the course is planned and conducted, the objectives should be referred to frequently in order to insure that there is an appropriate match between the instructional intent and the activities designed to meet that intent.

III. Outline of Specific Topics and Sub-Topics

A. Income and the Economic System

1. Employment
   a. Work opportunities for the aging
   b. High risk pre-retirement worker (age 45-64)
2. Income Maintenance Programs
   a. Social Security System
      1) Social Security Entitlement levels
      2) Supplemental Security Income
      3) Social Security reform
   b. Pension Programs
      1) Private - public pension
         a) Coverage of workers
         b) Vesting, portability
      2) Pension reform
   c. Other income maintenance programs
3. Expenditure patterns of the aged
   a. Cost of living (food, clothing, shelter)
   b. Health care (community-base care, institutional care)
   c. Consumer affairs

B. Work ethic - appropriate to the aging?

1. Retirement
   a. Variables affecting retirement (mandatory retirement, early retirement, cross-cultural comparisons)

b. Pre-retirement planning

c. Continued creativity (desire to work, productivity)

2. Poverty, dependency, pride

a. Nature of a fixed income (inflation)

b. Retirement as a just reward for productivity of a lifetime

c. Reducing poverty among the aging

1) Reducing expenditures

2) Increasing income (utilizing assets)

3. Volunteerism

a. Federal, state, local volunteer programs

b. Value of programs to older persons and others

IV. Instructional Methods

A. Income and the Economic System

1. Employment

Lecture and discussion. Encourage students to examine their experience with older people who have continued to work (neighborhood shop owners, clerks, professionals) and look at their own job situations (i.e., seniority practices, promotions, and demotions) in relation to age changes.

- Film - "Wise Years Wasted." Available North Texas State University, Center for Studies in Aging, Denton, Texas 76203

2. Income Maintenance Programs

a. Social Security System

- Lecture, background reading

- A guest speaker from the local office of the Social Security Administration could be used to outline programs and problems. Students could prepare questions ahead of time to promote discussion.

- Students, (either individually or in groups of two with one acting as the client and one acting as the Social Security employee) could fill out SSI application.

- In groups of three or four, ask students to prepare a budget using SSI income levels. Discussion should follow on the adequacy of this budget considering the cost of living, etc.

- Use of the "Trigger Films on Aging" available through the New York State Office for the Aging would be appropriate here, followed by a discussion (also available from the North Texas State University, Center for Studies in Aging, Denton, Texas)

b. Pension Programs

- Ask students to investigate the pension plan provided by their employer. What is contained in the fine print? How well do they understand the pension system under which they are covered? What level of income will they have after retirement? (If the student is not employed, use the plan covering his/her parents. Or, ask him to choose a job he would like to have and find out the coverage under that job.)

- Read and discuss the summary of the New Federal Pension Reform Act. What are the major improvements made by the new law? Where does it fail to fill gaps or meet needs in coverage?

3. Expenditure Patterns of the Aged

- Readings, lecture and discussion of basic needs and expenditures, tying this into former discussions concerning income levels.

- Invite a guest speaker from a local hospital or nursing home to speak on financing health care; what this involves for the patient and the provider of services.

B. Work Ethic - Appropriate to the Aging?

1. Retirement

- Readings, lecture, discussion. Group discussion for this unit should center around aspects of retirement and preparation for it. Along with income reduction, role changes, increased time, outside interests and marital/family relationships should be discussed. It is important to relate the discussion to the student's personal views and expectations concerning his/her retirement.

- A speaker from local industry, management and/or labor, to address the topic of pre-retirement preparation for workers.

2. Poverty, Dependency, Pride

- Films - "Does Old Mean Poor" available through North Texas State University, Center for Studies in Aging, Denton, Texas; and/or "Step Aside, Step Down" available through the New York State Office for the Aging and North Texas State University.

- Lecture, readings, discussion.

3. Volunteerism

- Film and speaker from the local RSVP program when available.

V. Evaluation Strategies

The choice of specific tests, papers, or other activities for evaluating student performance should be based on the situation's instructional requirements, the time available, and your need for information or feedback on student performance. Some suggestions are given below.

A. Testing

Objective tests can be useful in assessing student achievement on the cognitive objectives. Essay questions can be derived from the objectives if appropriate. Objective tests can be useful to the student in guiding his learning activities...whether or not they are needed for grading purposes.

B. Reports and Projects

Student reports and projects can be used both for evaluation and instructional purposes. Topics might range from a consideration of the effects of income on the nutritional levels of the older person to developing a new model for Social Security reform. These reports could be shared with, and evaluated by, the group as a whole, or may be submitted to the instructor for a grade.

C. Affective Objectives and Evaluation

Measurement or estimation of student achievement on the affective objectives can be difficult. Some information can be gathered by observing student participation in class

discussions, role-playing situations, or other activities. You may also wish to ask students to submit self-reports on how they feel their attitudes have changed as a result of the instructional experience. Grading decisions probably cannot and should not be based on information in this area.

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A. Employment

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Chapter V "Older Workers in Pursuit of New Careers" by Sidney A. Line. pp 39-56.
Chapter VIII "Major Problems of Industrial Gerontology" by K.F.H. Murrell. pp 71-84.
Chapter X "On Age Discrimination" by Harold L. Sheppard. pp 99-110.
Chapter XIII "Applied Research and Attitude Change" by William Torrence. pp 132-140.

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National Council on the Aging. Guidelines for the Development of Employment Opportunities for Older People, 1970.

The Nations Stake in Employment of Middle-Aged and Older Persons: A working paper prepared by the staff of the senior AIDES program of the National Council of Senior Citizens. Prepared for the Senate Special Committee on Aging, U.S. Senate, 1971. 80p. U.S. Government Printing Office HD 6280.N363 .35¢

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Annotation: These resources will provide information concerning the older worker and his difficulties in remaining in the labor force (e.g., Sheppard, Toward an Industrial Gerontology). They will also provide information with regard to older persons' concerns and desires with regard to employment and retirement (e.g., Toward a National Policy on Aging. Employment: Background and Issues).

B. Income Maintenance Systems

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Part I - Section Recommendations, "Income" pp 37-43.
Part II - Special concerns-sessions-recommendations, "The Poor Elderly" pp 151-159.

Hollister, Robinson. "Social Mythology and Reform Income Maintenance for the Poor." Annals of American Academy of Political and Social Science. September 1974, pp 19-41.

Tussing, Dale. "Dual Welfare System." Society, January 1974. A critique of the "Myth of Social Security Insurance," an evaluation of Social Security and SSI in the context of the total welfare system.

Annotation: Provisions of the Social Security Program are outlined in the first four references and proposals for change are delineated within the remainder. Robinson Hollister's article in The Annals is particularly comprehensive and informative.

C. Pensions

Cummings, Frank "Reforming Private Pensions," Annals, Sept. 1974, pp 80-95. Analysis of structure and primary weaknesses of private pension plans - underfooting, vesting, portability overfunding. Includes information and statistics from Senate Labor Subcommittee. Statistical Analysis of Major Characteristics of Private Pension Plans (1972). Article concludes with review of legislation pending in Congress.

Nader, Ralph and Blackwell, Kate. You and Your Pension. New York: Grossman Publishers, 1973. 215p.

"Explaining Pension Plan Jargon," Business Week, March 17, 1973.

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D. Expenditure Patterns

Riley, Matilda White and Foner, Anne. Aging and Society, Vol. I. "A Survey of Research Findings," New York: Russell Sage Foundation, 1968. Chapter 4, "Finances," pp 69-109.

Atchley, Robert C. The Social Forces in Later Life, Wadsworth Publishing Co., 1972. Chapter 14, "The Economy," pp 227-239.

"Facts on Aging" Reprint from Aging, May 1970. AoA Publication #146, U.S. Government Printing Office, Washington, D.C. 20402 .30¢.

Resources of People 65 and Over. Washington, D.C. Social Security Administration 1971. 45p. (SS Publication 1-71, Office of Research and Statistics) from U.S. Government Printing Office HE 3.2:R31/4.

Havighurst, Robert J. 1975. "The Future Aged: The Use of Time and Money." The Gerontologist, 15:1:10-15.

U.S. Senate. Special Committee on Aging. Consumer Interests of the Elderly. Washington, D.C., 1967 Parts 1 & 2.

Annotation: These resources outline consumption patterns, consumer problems, income levels, spending and saving patterns. Atchley and Riley outline the basics; the other sources promote a more in-depth exposure.

E. Retirement

Atchley, Robert C. The Social Forces in Later Life, Wadsworth Publishing Co., 1972. Chapter 9, "Retirement," pp 153-177.

Riley, Matilda White and Foner, Anne. Aging and Society, Vol. I "A Survey of Research Findings" N.Y.: Russell Sage Foundation, 1968. Chapter 3, "Work and Retirement," pp 39-68.

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Woodruff, Diane S. and Birren, James E. Aging: Scientific Perspectives and Social Issues, D. Van Nostrand Co., New York. Chapter 16, "Economics," pp 336-349.

Streib, Gordon F. and Schneider, Clement S.J. Retirement in American Society: Impact and Process. Ithaca, Cornell University Press, 1971 316p.

Annotation: These resources outline the issues involved in retirement. Again, Atchley and Riley present the basics, however, Streib is outstanding in this field of gerontology.

F. Poverty

Atchley, Robert C. The Social Forces in Later Life, Wadsworth Publishing Co., 1972. Chapter 8, "Finances," pp 139-153.

Brotman, Herman. Facts and Figures on Older Americans, SRS-AoA #181, DHEW - "Income and Poverty in 1972" - "Measuring Adequacy of Income" - "Poverty by State and Ethnic Group, 1969" - "The Older Population: Some Facts We Should Know."

Income, Background and Issues, 1971 White House Conference on Aging, March 1971. Washington, D.C.

Chen, Yung, Ping. 1965. "Economic Poverty: The Special Case of the Aged." The Gerontologist. 6:1:39-45.

U.S.Senate. Special Committee on Aging. Economics of Aging: Towards a Full Share in Abundance. Part 6: Retirement Community, Cape May, N.J. Hearing August 15, 1969.

Bisby, Lenore E. "Income of People Aged 65 and Older: Overview from 1968 Survey of the Aged." Social Security Bulletin, April 1970.

Annotation: Of these resources the most pertinant are Atchley, Brotman and Chen articles. Also the Background and Issues paper offers insights into the problem of poverty and the aged.

G. Volunteerism

Arthur, Julietta K. Retire to Action: A Guide to Voluntary Service. Nashville, Tenn., Abingdon Press, 1969.

Babic, A.L. "The Older Volunteer: Expectations and Satisfactions" The Gerontologist, 12 (Spring 1972), 87-90.

Annotation: These resources should be supplemented by an local resources available in the community, i.e., RSVP Programs, Salvation Army Programs, Volunteer programs organized through AAA's such as senior self-advocacy groups.

UNIT FIVE

ECOLOGY OF AGING

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UNIT FIVE

ECOLOGY OF AGING

I. Introduction: Ecology of Aging

In the last 10 years, there has been an increasing awareness that the environment in which people live has a significant impact on their quality of life. In the past, social and behavioral science has treated the concept of physical environment as a vacuum, or, at most, a stage on which human activity takes place. Much current research, however, has demonstrated that the physical world is an active influence on morale, social relations, self-perceptions, mobility, daily activities and other aspects of human behavior.

The Ecology of Aging concerns the relationships between older people and the settings in which they live - housing, community, transportation, institutions. These settings should be viewed as both physical and social environments.

The social environment of formal organizations, informal groups, cultural background and socio-economic class cannot be separated from the physical environment. They act together to affect and be affected by individual and group behavior in a complex set of relationships. An understanding of these relationships can help those involved in planning, designing and managing settings to more effectively improve the quality of life for older people.

Professional planners, environmental designers and managers are not the only people who have such an influence. Any individual who makes decisions about relocation, furniture arrangement, room assignments, personal safety or security, transportation and the like affects the relationship between a person and his social and physical world. Moreover, those who are the clients of professional planners, designers and managers should be aware of the implications of the products they commission. Consumers themselves would benefit most from such knowledge to insure that decisions made by others will be in their best interest. Better yet, they should be able to participate in such decision making themselves.

The Ecology of Aging depends upon a set of continually changing relationships. The physical environment changes all the time -- a new highway is built, a neighborhood deteriorates, a housing project is opened. The social environment is always in a state of flux - friends get older and die, new neighbors move in, new benefits are available for health care. However, these changes are not without human intervention and control, extremely important factors in determining ecological effects and human responses. Thus, the processes by which environments

are developed (including their management) are an integral part in understanding the ecology of aging.

This section provides an overview of major topics in the ecology of aging, identifies issues for in-depth treatment, described instructional resources, and suggests instructional methods for dealing with the material. The main topics covered are:

1. living arrangements;
2. community planning and urban design;
3. institutional living;
4. mobility and transportation;
5. responsive environmental design.

II. Living Arrangements

A. Overview

The most important ecological setting of the older person is their immediate living arrangement. Information basic to this subject is the demography of housing. The type and quality of one's housing is related to available income, type of tenure, health status, stype of community (urban/rural) and family status. Demographic data illustrates many trends in living arrangements among elderly people that are surprising to the uninitiated and helps to put housing and institutional living issues into perspective. For example, 70% of people over 65 own their own homes yet, income levels are very low. This indicates that maintenance costs, property taxes and utility bills are both immediate and major problems. Residential concentrations of older people are predominantly in inner cities and small rural towns. Lack of supportive services in such areas, therefore, will affect a great many older people. Another example is that only 5 - 7% of older people reside in institutions. The great majority of the aged live independently. Some research on the other hand, indicates that 25% of people over 65 die in an institution (not including hospitals). Thus, a significant proportion of older people will at some time reside in an institution for the aged. It is also important to consider demographic factors that are indirectly related to living arrangements; for example, minority group status, which is related to income and thus to quality of housing.

During the course of their lives, individuals go through housing cycles that are closely associated, yet often one step removed from major life events. Pastalan has described the loss-continuum that occurs with age and the cycle of housing relocation that begins with a move from the established family

home and ends with entrance to an institution. Congruence between a point on the loss-continuum and present living arrangements can predict how well these arrangements meet individual needs.

Categorization of living arrangements can be made through federal and state building and licensing programs; e.g., skilled nursing home, intermediate care facility. More appropriate typologies use characteristics that refer to aspects of environment meaningful for day-to-day life rather than for administrative requirements. For example, Kleemeir proposed three dimensions to categorize living arrangements - segregation/integration, control/autonomy, congregate/separate. These dimensions are useful in describing any type of living arrangement and in pointing out trends toward certain types. Generally, there is a continuum of living arrangements from the highly institutional (controlled life), skilled nursing care age-segregated setting on the one hand to the single-family house in the typical established residential neighborhood on the other.

Although many types of living arrangements are possible, there are typical kinds of settings in which older people most often live. They are:

1. Single-family homes.
2. Apartments for independent living.
3. Health-related institutions such as skilled nursing facilities and intermediate care facilities.

These settings have both pros and cons depending on the characteristics of the individual. Preference in living arrangements is for the greatest possible independence. Generally, research findings support a desire to live by oneself or with one's spouse on one's own home, although older people who move into housing projects for the elderly like them. Domiciliary care homes, mobile homes and retirement villages are settings that are increasing in popularity. The retirement hotel is another type of living arrangement still common in some places such as resort areas or central business districts of major cities. The programs available through federal and state government to finance construction and operation of certain types of settings have a major influence on what kind of living arrangements will be popular. For example, lack of programs for home care contrasted with availability of construction loans and reimbursement for nursing home care results in health-related institutions being built rather than congregate housing with supportive services.

If time is available and interest is high, you should include a discussion of financing and development mechanisms as well as supply and demand factors in housing.

B. Specific Objectives

1. Identify socio-economic factors in living arrangements.
2. Describe types of arrangements available.
3. Identify preferences for living arrangements.
4. Describe current trends and major issues.
5. Develop skills for analysis of living arrangements available in local communities.

C. Topic Outline

1. Demographic factors in housing.
   a. Male/female ratio
   b. Minority groups
   c. Income
   d. Family status
   e. Health status
   f. Home ownership
   g. Urban/rural concentrations
   h. Institutional residence
2. Individual housing cycles.
3. Spectrum of living arrangements.
   a. Segregation/integration
   b. Control/autonomy
   c. Congregate/separate
4. Typical types of buildings (pros and cons)
   a. Apartments
   b. Health-related institutions
   c. Domiciliary care
   d. Geriatric centers

e. Retirement villages

f. Mobile home parks

5. Preferences.

6. Financing and development mechanisms.

7. Supply and demand factors.

8. Older adult housing markets.

D. Instructional Methods

1. Assign readings with accompanying discussion questions.

2. Plan site visits to several types of facilities. Allow enough time to be given tours in small groups with residents as guides and to have discussions with the administrator or manager and groups of tenants.

3. Have a team of students develop an inventory of all housing and institutions in the community that serve the elderly. Include information on number of units, waiting lists, admissions requirements, etc. This can be used both by local agencies and as a means to acquaint students with the spectrum of living arrangements.

4. Have a team of students analyze census data to show the concentrations of older people in the community. This is best done on a map showing each census track. Try to determine why there are high concentrations in certain areas.

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III. Community Planning and Urban Design

A. Overview

The community can be viewed as an ecological system made up of housing, major institutions and a transportation and communications network. The proportion of older people in a community is a major factor in its response to the needs of its aged population. Just as statistical profiles can be developed for nations, they can be prepared for communities to show trends and how much of the total population is within certain age ranges. Communities can be typed according to their age structure. For example, a newly developing "Gold Rush" community is likely to have few older people. Community age structure is dynamic and responds to economic and social trends at national and international levels. Thus, rural towns which at the time had balanced age structures experienced heavy out-migration of young people since World War II. Now many have very high proportions of older people. Age structure is important in determining the extent of such needed services as transportation. Developing trends also predict needs for new housing and health care services.

An important factor in community age-structure is the rate and type of residential migration. It is also important in understanding community political dynamics. Urban areas have experienced out-migrations of younger affluent people. With larger populations of older and poor people, they require greater services, yet cannot afford them. Once "young" suburbs, however, are now maturing. Many suburbs will soon be faced with the need to provide services and facilities for their increasing aged population without any experience in such matters. The pattern of migration differs from place to place, depending on local dynamics and the existing setting. In a recent study Golant has shown that, in Toronto, a metropolitan area with high density housing in the suburbs as well as in the city, the pattern of migration of older people is toward the suburbs. In the U.S., it has been toward the inner city, where most high density, low-cost housing has been built. Golant's findings suggest that U.S. cities developing housing markets like Toronto will also be experiencing such patterns. Migration patterns can be an

important influence on social changes. Such changes can be both a detriment and a benefit to older residents. More older people in an area increases their political influence and improves friendship formation. Less older people can have the opposite effect. In addition, in-migration of young, low-income populations or students can drastically affect the physical and economic security of the older person.

Age segregation is a major issue in urban design and housing programs. Most subsidized housing for the elderly in the United States is age-segregated. Evaluations of this housing demonstrate that it is well received and provides, among other benefits, improved social relations and health. Findings from limited research in age-integrated settings show that older people in such settings do not maintain friendships with young neighbors. Age-segregated housing is also the best way to provide security in high-crime areas. On the other hand, limited research findings among people who live in age-segregated housing show a preference for neighborhoods with a high density of older people but also people of other age groups. There may be many societal benefits of age-integration, not the least of which could be improved understanding of old age among young people who now demonstrate an overwhelmingly negative stereotypical image of age. However, few intentional efforts have been made to develop age-integrated settings with a high density of older people and with adequate security.

In recent years, there has been much discussion about alternatives to institutional care. The major obstacle is the lack of coordination of services. Successful alternatives have been provided in places that managed to develop community-wide home care programs, geriatric day-care and institutionally sponsored sheltered housing.

Site selection for housing, health care, social service and recreational facilities is one of the most critical concerns in coordinating social and physical planning. Ideally, long-range planning efforts should be developed with a close look at migration patterns, age structures of neighborhoods and the needs of neighborhood residents. Site selection criteria should be developed that do not allow good programs to be ineffectual because of poor location, e.g., the senior citizen center located next to a liquor store or the housing project for the elderly in the most dangerous neighborhood in town.

B. Specific Objectives

1. Develop an understanding of community age structure and its impact on planning.

2. Develop the skill to recognize patterns of change in community age structure and their implications.

3. Identify trends in residential migration and develop an understanding of the effects of those trends.

4. Develop an objective perspective on age-segregation.

5. Present research findings on age segregation.

6. Demonstrate the importance of community planning in developing alternatives to institutional care.

7. Present planning strategies that are examples of successful alternatives to institutional care.

8. Highlight the importance of site selection to service delivery.

C. Topic Outline

1. Age composition of communities and its dynamics.

2. Community typology by age structure.

3. Age segregation and integration.
   a. Causes and trends
   b. Pros and cons
   c. Preferences
   d. Underlying processes

4. Migration and social change.
   a. Residential mobility
   b. Past events and current trends

5. Planning alternatives to institutional living.
   a. Coordination of shelter and social and health services.

6. Site selection for housing, health care, social service, and recreational facilities.

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D. Instructional Methods

1. Have students prepare age-pyramids from census data of various communities in the local area.

2. Have teams of students prepare maps from census data that show patterns of in-migration and out-migration and explain the reasons for these patterns.

3. Have a debate on age-segregation with two debating teams of students.

4. Invite local planning officials and outspoken older people from the community for a panel discussion on current planning issues.

5. Assign readings with accompanying discussion questions.

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IV. Institutional Living

A. Overview

The origin of the modern nursing home is the chronic care ward of hospitals and small "convalescent homes" where those hospital patients needing extended recovery time would go before returning home. As medical costs rose, chronic care wards became too expensive and the convalescent home developed to take care of those who needed constant supervision and daily nursing care at a reduced price from hospital costs. Some homes for the aged, usually with little medical or nursing care, began as places that served people who could not find a home elsewhere. Progenitors of public homes of this sort were county "poor-houses." Mental hospitals were also used for the purpose of providing shelter to the homeless. As residential mobility of young people increased and multigeneration families no longer lived together, the nursing home became more popular as a living arrangement for chronically ill older people. The demand for such places increased as chronic illness due to increased life expectancies and new medical technology became more prevalent. The advent of Medicare and Medicaid also added to the demand, not only because of the influx of people who could not afford nursing home care but also because of the exodus from state mental hospitals. Medicare and Medicaid provided a means for states to transfer the costs of caring for older people to federal reimbursement programs.

There is a wide variety in the types of total institutions serving the aged. Classifications vary from state-to-state. Medicare and Medicaid and state agencies have regulations governing care programs and facilities for the various classifications. There are major differences in management patterns and in the physical environment of institutions, not only among classifications, but based on differences in ownership, administrative expertise, size, location and clientele group served.

Several studies of nursing homes have recently been completed. Some, such as the Nader organization's study, have given thorough background information about the nature of the industry and much anecdotal material on poor living conditions and treatment. Gottesman's study, a substantive scientific analysis of nursing home services, provides more objective information on nursing home life and identifies problem areas for effective intervention. Research on the effects of institutionalization clearly demonstrates that

alternatives to nursing home care should be found. There is much evidence that many people currently in skilled nursing homes do not need that level of care. In some states, such as New York, a move toward providing lower levels of care has already begun. Unfortunately, this response is based on a need to lower costs of care and to avoid closing older institutions as standards are raised in response to scandal. The major scandals have been in regard to unsafe and unsanitary facilities, financial manipulations with huge profits, poor quality treatment in medical, nursing and custodial care.

The problems of institutions for the aged may be traced back to the origins and rapid development of these institutions after initiation of reimbursement programs for medical and nursing care. Originally conceived in a medical rehabilitative model, it soon became apparent that nursing home stays average from one to three years and most residents can not be significantly rehabilitated. These findings suggest a residential model for providing care at the person's own home or congregate living arrangement with relocation to skilled nursing facilities as last resort. Such a system is operating effectively in other countries but has not been implemented in the United States.

Developing alternatives to institutional care has floundered due to lack of appropriate funding mechanisms although the geriatric day care center has demonstrated success for people with psychiatric problems but relatively good physical health. Another promising alternative is outpatient care through large "Geriatric Centers." The costs of alternatives such as community home care programs are comparable to nursing home operational costs, but the cost of building independent housing units is much less than the costs of institutions, oh the other hand, have forced increases of scale in the size of facilities and, thus, a more institutional living environment.

One of the major issues in institutional living is relocation of residents into the institution and from one institution to another. Relocation has been shown by many investigators to be related to mortality, given certain conditions. Successful programs for supportive relocations can be developed, but often they are overlooked since mortality is an expected event in institutional life.

If time is available and resource people can be obtained, it is a good idea to explore trends in institutional living. Important issues here are the effect of higher standards on the supply of nursing home beds, efforts to make nursing home

operators accountable, the causes and implications of new classifications of institutions at lower levels of care, and the trend toward larger nursing homes with multiple levels of care and services. Another area of importance is a discussion of the local process for awarding permits to build and operate homes including efforts toward utilization review and regional planning of health care services.

B. Specific Objectives

1. Develop an understanding of the nursing home industry, its historical roots and developmental trends.
2. Provide an inside look at day-to-day life in a nursing home.
3. Develop an objective perspective on the quality of institutional care.
4. Present the major criticisms of institutions.
5. Identify constraints to alternative methods of care.
6. Provide information on promising alternatives.

C. Topic Outline

1. Historical development and purposes.
2. Classifications of health related institutions.
3. Research findings on the effect of institutionalization and factors related to quality.
4. Problems of accountability and perspectives on scandals.
5. Medical versus residential model of institutional care for the aged.
6. Alternatives to institutional care and implementation constraints.
7. Costs of institutional care versus costs of alternatives.

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8. Criticisms of institutions.

9. Relocation.

10. Future trends in institutional living.

D. Instructional Methods

1. Site visits to nursing homes.

2. Individual assignments to spend at least eight hours in an institution observing activities and presenting a description and impressions for class discussion.

3. Readings on both investigation oriented studies and scientific research on institutionalization.

4. Panel of people engaged in community decision making on long-term care; e.g., bed allocation, utilization review, visitor programs.

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V. Mobility and Transportation

A. Overview

Mobility in the community is a major factor in the quality of life. Extensive research on the mobility of elderly people has shown that they differ from younger people in type of travel, peak travel times, and purpose of trips. Older people then seem to have different transportation needs than the rest of the population. It is apparent, for example, that they rely more on public transportation. But public transportation is usually geared to mobility patterns of younger people and travel to work.

Work on the correlates of mobility demonstrates that different segments of the older population have quite varied mobility patterns based on income, membership in ethnic groups, type of neighborhood and affinity groups. Pedestrianism is an important mode of mobility among the aged, yet they are generally unhappy with it for a variety of reasons. One of the difficulties is environmental barriers such as high curbs, difficulty crossing complex intersections and long distances to shopping areas. For the physically impaired, these problems are severe restrictions on mobility as are public transportation systems that are not designed to be barrier-free. A major reason for the reliance on pedestrianism is low income and high vehicular transportation costs.

A major trend in solution of mobility problems of the elderly is subsidized fares on public transportation. This has been financed in a variety of ways including such innovations as the proceeds from the state lottery in Pennsylvania. Solutions such as call-a-bus that serve people with physical mobility limitations can have a great impact on their quality of life. However, the costs of using such systems and constraints of availability and insurance problems limit their usefulness.

UNIT FIVE

B. Specific Objectives

1. Highlight the importance of mobility in the day-to-day life of the older persons.

2. Describe differences in transportation needs between young and old users.

3. Identify current solutions to mobility problems and their limitations.

C. Topic Outline

1. Mobility patterns

   a. type of travel

   b. peak times

   c. comparison with other groups

2. Correlates of mobility

3. Pedestrianism

4. Mobility barriers and problems

5. Transportation solutions

   a. public transportation

   b. reduced fares

   c. call-a-bus

D. Instructional Methods

1. Have students ride public transportation, a call-a-bus, and talk to elderly users.

2. Readings with accompanying discussion questions.

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VI. Responsive Environmental Design

A. Overview

In recent years, many environmental design professionals, architects, industrial and interior designers, landscape architects and planners, have turned away from what some of my colleagues call the "edifice complex" or "facadology" to a new perspective of design. This new perspective is that human behavior should be the basis for design; that the safety, comfort and welfare of the building user should come before the glorification of the designer. Although this viewpoint has not yet gained wide acceptance, it is growing in popularity. It is most relevant when considering environmental design for the aged because, on the whole, the aged are far more sensitive to the physical environment than other age groups, except perhaps young children.

White's concept of competence is useful in developing principles of design for this age group. He suggests, backed up by the research findings of others, that people are always striving to gain effectance over their environment - it is a basic motivational drive. Maslow proposes that self-actualization, a similar concept, is the human goal of the highest order, but that individuals must satisfy other goals such as safety, security, belongingness and self-esteem before self-actualization can be fully realized. In planning and designing for the aged, it is important to include self-actualization and effectance as programmatic considerations, yet it also is important that the other goals be satisfied, otherwise self-actualization is not likely to occur.

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The psychology and sociology of aging make it clear that older people are quite diverse in personality and social characteristics. One of the greatest failings in existing design for this group is the lack of choices and the rigid stereotypes of behavior that have been enforced by the built environment. This is not solely the fault of designers - much of it is due to inflexible practices. In the next decade, provision of choices and an environment that recognizes diversity in life style and values should be a primary goal. Sometimes it seems better to make compromises and get something built or implemented than to be stubborn; however, we have to realize that large buildings are mortgaged for forty years and once they're up, it is very difficult to change them.

Research into the effect of the physical environment on human behavior, much of it focusing on older populations, identifies many means through which supportive and self-actualizing environments can be created. Environmental barriers to access and use by disabled or frail people can be removed. The blunting of the senses that is associated with aging can be compensated by "sensory nourishment," using redundant cueing and higher levels of meaningful stimulation. Sensory-motor slowness can be dealt with by reducing demands for quick action and requiring only simple responses in times of emergency. Principles of defensible space design can be used to insure security without making a building a fortress, and thus, a prison. Life safety can be enhanced by fire and accident safety design considerations. Social relations can be facilitated by increasing perceptual, physical and functional proximity between people. The use of "sociopetal" environmental arrangements can enhance the amount and quality of social interaction. provisions to insure privacy by control over information about oneself can be provided, especially in institutional environments.

The meaning one attaches to parts of the built environment can be determined by studying cognitive images of buildings, neighborhoods, and cities. These meanings are based on a life-long pattern of experience. They determine responses to new settings and changes in existing settings. Design and planning that seeks congruence between design products and valued images of older people can go a long way toward being responsive to their needs.

People who do not understand the environmental development process often are unaware that they can affect it. Many designers, through frustration, have come to the conclusion

that they have little control in the face of powerful political and private interests. This is not always the case, particularly when large numbers of voters can organize behind a position on an issue. Advocacy groups of older people like the Gray Panthers and ACCORD (Syracuse) are discovering that they can have an effect on environmental development by publicly challenging unwise decisions of planning agencies and housing authorities. Other strategies are to develop consulting relationships with agencies and to work dilitently in grass-roots community development decision making. The Housing and Community Development Act of 1974 provides mechanisms for consumers to have a voice in such decisions, although the effectiveness of their input is likely to vary from place to place.

Perhaps the most critical areas for environmental action for the benefit of older people are in efforts to revitalize inner cities and rural areas where large concentrations of older people live. Such efforts can lead to many benefits including increased security, improvement of energy utilization in housing (lower utility costs and better thermal comfort), increased mobility, better social relations and improved self-esteem. Older people have as much to gain from revitalization effort as anyone else who lives in locations where it is needed, but they often are overlooked in favor of more vocal and more visible citizens. It is important that elderly residents be heard, but it is often dangerous for others to speak for them, lest they misinterpret or push forward their own, possible divergent values.

You should review the research material on the effects of the physical environment on human behavior. If your students are interested in other topics in the outline, you might explore them in more depth.

Resources on environmental action are hard to come by. The best source of material are those people active in it. You might contact such people and ask them to review their efforts as case study examples either in person to the class or to you as intermediary. Local planning officials can be helpful in this area for obtaining references or recounting local issues.

UNIT FIVE

B. Specific Objectives

1. Present basic principles for environmental design with the older person in mind.

2. Develop enhanced environmental awareness; i.e., how the environment affects everyday life.

3. Encourage people to take action in affecting change in design and planning activity.

4. Give an introduction to research in environment and behavior issues.

5. Show people how they can be influential in affecting change.

6. Highlight the role of consumers in expressing their own value decisions for themselves.

C. Topic Outline

1. Environmental support and competence.

2. Environmental barriers.

3. Sensory nourishment and expanded time frames.

4. Security and safety.

5. Social relations and proxemics.

6. Privacy.

7. Cognitive images and developmental patterns of spatial behavior.

8. Current legislation and trends.

9. Local environmental action.

10. Urban and rural revitalization.

D. Instructional Methods

1. Readings with accompanying discussion questions.

2. Observation visits to local hearings and community meetings where environmental development decisions are being made; e.g., local health planning.

3. Guest lecturers who are consumer advocates.

4. Use of empathic simulations of disability; e.g., blindfold students and have them move around the room, put students in wheelchairs and have them go on a scavenger hunt.

5. Invite a police chief to discuss incidents of crime against older people or a fire chief to discuss life safety issues.

6. Invite an environmental psychologist or other research in the environment and behavior area to discuss a topic in-depth.

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UNIT SIX

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UNIT SIX

SECTION - A

HEALTH

Objectives

The student will be able to:

1. Define conditions which help maintain the well-aged or healthy person.
2. Utilize the concept of man's continuous interaction with his environment in maintaining health.
3. Create a climate conducive to health and well being.
4. Facilitate the continuance of health education and development of positive health practices throughout the life span.
5. Identify behaviors that promote health and prevent disease.
6. Assist older persons to maintain their mobility.
7. Identify significant physical and mental changes in the aging person.
8. Explore major health problems of older persons.
9. Encourage health screening assessment at periodic intervals.
10. Identify the older person's perception of his health problems.
11. Help the older person explore his understanding of his disease.
12. Help the older person define his health needs.
13. Share information with the older person about illness so that he may actively participate in the rehabilitative process.
14. Help the older person explore the consequences of illness for him.
15. Help the older person identify his capacities and limitations.
16. Facilitate and encourage the older person and his significant others in responsibility for his health and illness care.

UNIT SIX - A

I. Health

Health is a major area of concern to older persons. A research sampling of needs of non-institutionalized older persons in Chicago found that older people ranked health second only to income as a need. In another study of 100 older persons living in the community, health and physical care was their prime need. The absence of a means to satisfy these needs promotes anxiety, and anxiety level is intimately related to health.

Health is defined as a state of physical, mental and social well being, not merely the absence of disease. A major concept of health is man in process with his environment. No act of individual behavior is unrelated to the social space in which it is occurring. Body and society are in constant interaction. We must consider always the segment of the world in which one lives as a significant part of any health assessment. Conditions necessary for life are found neither exclusively in the person nor exclusively in the outer environment, but in both at once. Health and disease, as phases of life, are dependent at any one time on the balance maintained while fulfilling needs and adapting to and mastering stresses as they arise. Health represents the phase of successful adaptation, and disease the phase of failure. Hence, every disease is a disruption in the dynamic equilibrium and is a psychosomatic, psychosocial and a biosocial uneasiness.

What part of the disease is in the body, the person, or the human group? Much of what goes on inside bodies is intimately related to what goes on between bodies. The family system has tremendous impact on health beliefs and responses to detection, acceptance and treatment of illness. The use of group methods, particularly the family group, for health education and for reduction of intrafamilial tension is vital in promoting health.

Many of older persons' problems in relation to the health-illness continuum are related to various cultural and societal events and beliefs. Some of these are the equation of aging and illness; the conception that the sick role is necessarily experienced in an institution, isolation from (kinship) support, downward social mobility, often with a loss of status, caused by retirement and loss of work role. All of these factors unduly and perhaps unnecessarily stress the aged person in our society.

Disease and chronic illness, accidents, air pollution reactions, psychosocial stress responses, and suicides are major health problems for all of us. Sick role experiences and inadequate, reluctant or tardy access to the resources for the prevention and treatment of disease and uneasiness compound the problems of health care for the older person. The problem is compounded by an uncoordinated health care delivery system (which many have called a non-system) which has not been responsive to the health needs of many groups. One of these groups is the older citizens. The goal of effective disease-detection and disease-training processes to increase and maintain wellness and to reduce the prevalence and duration of illness is not attainable for the vast majority of older and middle age persons who are or will be at increased risk. This is especially true of those in the lower socio-economic groups where the prevalence and incidence of disease is the greatest. Some of the goals for a health delivery system are:

1. Every individual will have equal access to needed health services - preventive, diagnostic, therapeutic and rehabilitative.

2. Coordination and continuity of health services will be available to all individuals.

There are many health services for older persons but the major gaps in services and the difficulty in access to services are not clearly defined or changed because there is no strong service coordination. A large variety of alternatives made available to older persons at any entry point into the health delivery system is essential to maintain as many options as possible for older persons. The goal of an extensive co-ordinated system is to maximize the older person's integration into the community. The view of older persons as capable citizens in need of continuing growth and challenge is vital. The services for older persons would be integrated with services for all ages for a more normalizing, humanizing set of alternatives for older citizens. These services would include health aids, co-residents options, interior redesign, respite services and respite residences and transportation services for older citizens.

II. Health Education

There are physical and biological changes in the process of growing old. Therefore, the older person can be considered at risk to onset of illness even though he appears well. The present generation of older persons is conditioned to life-long

habits of health care, one of which is seeing a doctor only when ill. To deal with potential health problems of the aged who are well, we need to institute preventative measures, such as regular periodic physical examinations, screening programs, and health education programs. The goal is to help a vulnerable older population to define areas and take action in areas where prevention and early treatment make a significant difference.

1. Before asking an older person or group of older persons to develop new health habits, find out their existing health habits, how these are linked to each other, and what meaning they have in the person's life and social world.

2. Start where the person is in his health knowledge.

3. Present your health information so that it makes sense to the older person.

4. Find out current concerns in the older person's life and link new health information to his or her reality concerns.

III. Preventive Health Care

A. Health Promotion (the maintenance of health)

1. An older person can be defined as when he or she can:

a. Ambulate with or without devices.

b. Perform the necessary activities of daily living.

c. Strive to improve physical and mental well-being through health activities.

d. Seek professional guidance as necessary for continued independent action.

e. Pursue goals that promote self-actualization.

f. Be free from acute symptoms of disease and accident.

2. The prevention of some episodes of acute illness particularly respiratory distress, accidents and disabilities, and complications of disease can be accomplished by means of diet, directed exercises, and following medical regime.

3. Help the older person become aware of areas of need by doing a health history.

4. Assist the older person to get self-help devices to maintain independence, especially such things as well-fitting dentures, eyeglasses, hearing aids, etc.

5. Screening programs for early detection and treatment are very important. Undetected disease such as glaucoma and diabetes could be treated and complications limited by early detection and treatment.

6. Health education programs and exercise programs are designed to minimize accidents and to help the older person adapt to physiological change attendant to the aging process. (Falls are the largest single cause of accidental death in the aged and account for half of the deaths in this age group.)

7. Nutrition. Adequate diet is essential to maintenance of health. Nutrition programs have received top priority in Federal legislation.

B. Primary Prevention

1. Prevention of illness

Preventive behavior is that behavior which individuals actually do in order to avoid getting ill. Some of the essential factors that are related to the prevention of illness are as follows:

a. Awareness factor - The older (or any age) person himself or with support must become aware of how vulnerable he is to getting a disease. He must assess the risk of getting a disease and must have some data about the seriousness of the disease.

b. If we are to help the older person prevent illness, we must link the preventative behavior to something he wants or to a life goal that is important to him.

c. The person must become more aware of his body's responses and must monitor body changes. Thus, he must be sensitive to bodily cues.

d. Older persons, as do all people, weigh the benefits of taking action in relation to the costs. This may be a greater factor in the older person because of fixed incomes.

e. Significant others play a major role in encouraging the person to go for health care. Isolated older persons lack this significant other so the healthy person must often play this role of initiating, encouraging and facilitating health care.

f. Enabling services are often needed by the older person to get the health care he needs. These services may be referral, transportation, escort services, etc.

g. A regular physical examination provides base-line data and facilitates early detection and treatment.

h. Multiple Screening - much illness reaches an irreversible point before diagnosis is made and definite treatment undertaken. A series of twelve tests can be done in under one hour without a physician. Multiple screening is the identification of unrecognized disease or defect by the administration of tests or procedures which can be applied rapidly.

C. Secondary Prevention

Acute, short-term illness of the aged is not the major health problem; chronic illness is the most pressing problem. In a study of older ambulatory persons with chronic conditions using clinic facilities, 35% felt they needed more information about their illness. 17% of this population had no emergency assistance available. To help older persons with chronic illness, we must listen sensitively, speak to the feelings, not just the intellect and devise more precise, simple and effective ways of teaching health.

An outstanding characteristic of the above study was the ability of older persons with chronic illness to assume full responsibility for their daily life in spite of multiple chronic illness. Ninety-five percent of the people, regardless of their chronic impairment, live in the community. Thus, older persons with chronic illness feel that it is hard for them to manage medications, food, ambulation and leisure time activities.

Older persons spend higher proportions of their income for health-related services than do younger people. A larger portion of the fixed incomes is spent on drugs. Although the aged represent approximately 10% of the total population, they pay over 25% of all costs for prescription drugs. That is, they spend 3.3 times the amount spent by those under 25.

Eighty percent of chronically ill persons living at home in the 75-79 age group made medication errors in one study. All errors and serious errors were made most frequently by persons whose marital status had changed. The risk of making errors in medications increases if the person lives alone.

This data indicates a need for marked increase in the number and kind of support services to be developed in order to help maintain older chronically ill persons in their home.

In all age groups of chronically ill persons 60-69, 70-79, and 80 and over, one-third had inadequate diets. The persons who lived with two or more people had a better chance of eating well than those who lived or ate alone. Loneliness is associated with poor diet. People who rated their illness as a "big problem" were high risk candidates for having inadequate diet.

Activities outside home are limited for the chronically ill, ambulatory older person. Seventy-nine percent of those who find it heard to travel have fewer than three activities outside the home per month. The proposition is that the chronically ill older person who has trouble in one important realm of living is likely to have trouble in other realms too.

Chronic disease is long lasting, caused by permanent, non-reversible, pathological alteration. Halting the progression of disease and preventing the complications of disease and disability limitation are the goals of secondary prevention. Rehabilitation's major emphasis is to maximize all capabilities of the person.

Forty percent of all chronically ill are over 65. Three-fourths of all aged persons have one or more chronic diseases. Fifty-five percent of all chronic illness with limitations in mobility are aged.

Supportive services are needed to delay, reverse or avoid institutionalization. Some of these services are public health nursing, housekeeping help, home health aids, meals-on-wheels, central referral service, day centers, night hospitals and rehabilitation centers.

A great deal more research is needed on chronic conditions if we are to prevent the occurrences and the disabling effects of chronic diseases.

The needs of the older person who is chronically ill may be very special but the needs of the chronically ill are universal; to live fully, to be part of the mainstream and to achieve and maintain independence. The elderly poor suffer more, receive less treatment and are over-burdened by the cost of care and services. Studies indicate that a crucial relationship between mental health and physical health exists.

UNIT SIX - A

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UNIT SIX

SECTION - B

LEGAL RIGHTS OF THE ELDERLY

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UNIT SIX

SECTION - B

LEGAL RIGHTS OF THE ELDERLY

I. Introduction

The purpose of this section is to introduce some of the major legal concerns of the older American. It is meant to give the worker in the field an awareness of the complexity of the concerns and how he might be able to assist and direct an older person with such problems. This section will outline basic information on consumer protection, Social Security and Social Welfare Programs (including Medicare and Medicaid) and legal housing rights and living arrangements of the elderly.

There is often little that a non-legal professional can do except to be aware of the issues and know where to look for help and answers. It is important to keep in mind the concept that the aging individual is the same, under the law, as other adults; however, because of age, income, health, and societal factors, the aging individual often has increased vulnerability to legal problems. At the same time, by statute and upon meeting certain requirements, old Americans are entitled to certain rights that others are not: Social Security, certain tax reductions, subsidized medical care and housing, etc. Another important part of this section is an attempt to identify resources such as state and local agencies and other sources of information that can be used as guidelines to the legal rights of the elderly.

The literature concerning legal problems of the aging is often written in a technical fashion for lawyers working in the field trying to better understand the aging legislation. Since the 1960's, when the Office of Educational Opportunity programs began to provide legal services to the poor, many of whom were elderly, much has been written to educate and train professionals in this new field of "poverty law."

Sources of legal information and advice on coping with legal problems often comes from the research and information services of senior citizens groups such as AARP/NRTA or the National Council of Senior Citizens. Information from the White House Conferences and the U.S. Senate Special Committee can also be helpful in outlining the issues.

Perhaps the most useful source of information on the topic is the book "Materials on the Legal Rights of the Elderly" (see Bibliography) which is an assemblage of pertinent information

on the issues put together for non-legal professionals working in aging.

II. Objectives

As a student of this section, you should begin to develop:

1. An insight into the legal problems that confront an elderly individual.

2. An awareness of the services available and the administrative procedures for obtaining the services.

3. An awareness of the devaluation of the older person in our society with regard to his/her legal rights in maintaining an independent life style.

4. An awareness of the vulnerability of the elderly to consumer frauds.

5. An understanding of the Social Security and Social Welfare Programs (including Medicare and Medicaid) and the eligibility requirements.

6. A familiarity with the basic housing rights (non-institutional and institutional) of the elderly.

III. Consumer Protection for the Elderly

Protection of the consumer in the marketplace is a relatively new sphere of the law which is expanding rapidly. Consumer protection is especially important to the eldelry population for two reasons. First, the elderly are particularly susceptible to false promises of merchants. Second, the financial loss from fraudulent transactions is more difficult for them to bear because most elderly persons are on a fixed income.

As a non-legal person working with the elderly, instances of consumer fraud are apt to come to your attention through other concerns in the life of the elderly person which you have been specially trained to handle. When this happens, inquire further into the situation until you are certain that you have all of the facts necessary to understand the problem completely. Since laws governing consumer protection are constantly protection, your next step is to contact an organization which is qualified to help you evaluate the situation and to obtain redress for grievance.

Knowing the correct consumer agency or legal aid organization to contact is an art, since each agency has a slightly different function and approach to consumer problem solving.

One of your most important functions is to learn something about the scope and specialties of each agency through your own experience and the knowledge of your co-employees. In New York State, the most expansive agency handling individual consumer complaints is the Consumer Fraud Division of the New York State Attorney General. There is a Consumer Fraud Division in every major city in the state. If you are located in a town, the office in the nearest large city will have the authority to handle your problem. The office has a special complaint form which consumers are requested to complete and mail in to register a complaint. It would be wise for persons dealing regularly with the elderly to have a large number of complaint forms on hand in order to afford the elderly person assistance in completing the form immediately. The complaintant will be contacted by mail when his complaint is evaluated by a professional complaint investigator or an attorney, and will receive copies of all letters to and negotiations with the merchant. If negotiations fail, and the Attorney General finds actual fraud by the merchant, he will ordinarily prosecute the case at no cost to the consumer. In cases falling short of actual fraud where the Attorney General has been unable to successfully negotiate on behalf of the consumer, he will recommend that the consumer either hire a private attorney or take the case to Small Claims Court.

The major problem for an elderly person with retaining an attorney is expense. Legal aid organizations, which are found throughout New York State in all large cities, provide free legal counsel to clients who fall below certain income standards. As a person dealing with the elderly, you should familiarize yourself with the eligibility requirements of the nearest legal aid organization in order to determine whether to refer the elderly person to the organization. Since most legal aid organizations are funded by the government, the eligibility standards tend to be uniformly low throughout the state. However, some privately-funded legal aid societies will counsel a client for a nominal initial fee, and will advise the client of his chances for a successful case in court. Therefore, if an elderly person does not meet the eligibility requirements of a government-funded program, you should be aware of alternative means of low-cost legal representation. It would be wise to establish contacts with a particular person at a legal aid organization, who you can telephone regarding referrals and problems, and who you know will be sensitive to the special problems of the elderly.

Although you may have heard of and may wish to contact the newly-created State Consumer Protection Board in Albany, this office does not handle individual complaints and is not the organization to contact with a problem. However, many city and county governments throughout the state have instituted

consumer affairs offices to assist the consumer in disputes with merchants, and to put the consumer in a more equal bargaining position in the marketplace. Many offices were established under Consumer Codes, which enumerate business practices made illegal in the area governed by the Code. It is usually the duty of the consumer affairs office to enforce the Code, although many offices do not have the capacity to bring cases into court because of an inadequate legal staff. These offices can be effective in resolving disputes in the negotiation stage, and tend to have a more informal approach which may be particularly helpful for an elderly person who does not have any idea of the legal intricacies of his problem.

Another forum in which the elderly consumer can obtain relief without counsel is Small Claims Court. This court does not require representation by an attorney, and the judge may waive the usual rule of evidence. Its purpose is to let each party give his side of the story in laymen's terms, and to render a prompt judgement. Depending on your location, the Small Claims Court will have the authority to handle claims of up to $500 or $1000, and larger claims must be brought in another court. The procedure for filing a claim is intentionally simple; it will usually entail relating the problem to the court clerk and paying a nominal filing fee. The clerk will alert the consumer and the merchant of the date and time to appear before the judge. If the elderly person resides in a town, he must bring his small claim before the town justice.

It is important for the professional working with the elderly to know the procedures of the closest Small Claims Court, such as hours and places for filing a complaint and costs involved. Although the Small Claims Court is intended to be a forum accessible to the average person, any person may be hindered from utilizing this forum by the fear of appearing before a judge, difficulty in relating his problem, or lack of transportation to and from the court. Local consumer affairs offices sometimes accompany consumers to Small Claims Court, and you should investigate the existence of this service in your community. Alternatively, the elderly person may be accompanied into court by a relative, friend, or professional.

Most consumer protection is relatively recent. Although the amount and type of protection varies from state to state, you should be familiar with the following New York State statutes which deal particularly with consumer problems affecting the elderly.

1. New York General Business Law, Article 28-A: Cemetery Property and Funeral Services

   This article enumerates unlawful acts relating to sales and advertising of cemetery property. It prevents unauthorized charges in connection with permits for burials or erection of monuments. The section further requires that monies paid to a funeral director or cemetery for services not to be rendered until the death or burial of a person be held in a separate trust fund and be repayable on demand at any time prior to the rendering of services.

2. New York Personal Property Law, Article 10-A: Home Solicitation Sales

   This article gives the buyer in a sale transacted at a place other than the seller's place of business three days to cancel the sale. The sale must be of consumer goods, and payment must be over time. A similar federal law does not require payment over time, but is only applicable to sales of $25 or more. The law requires that a seller provide the buyer with a detachable card advising the buyer of his right to cancel. If the card is not provided, the buyer may cancel at any time. This provision may be especially useful to the elderly consumer, since he is often the subject of high-pressured sales in his home.

3. New York General Business Law Section 396

   This section provides that, whenever a consumer receives unsolicited merchandise in the mail, it shall be considered to be an unconditional gift. The recipient may use the merchandise in any manner whatsoever and is under no obligation to return the merchandise or to pay the seller. Threatening notices of the seller may be disregarded, or should be sent to the State Attorney General's Office.

4. Defective Products

   The problem of defective products plaques all consumers, who are usually unaware of their rights under warranties laws. What do you do when a product breaks down after two months? The New York State Uniform Commercial Code provides relief from defective products, as well as the Federal Warranties Act which became effective in July, 1975. The most important factor to be aware of when this problem occurs is to instruct the elderly person to promptly notify the seller of all of the defects, and to give him an

opportunity to correct the defect. This should be done in writing, with a copy kept by the consumer in the event of court action. In some instances, the elderly person will be entitled to receive a new product or a refund. Do not be misled by language limiting the warranty to a certain number of days, because this may not be legally valid. Refer your client to a legal services organization, if possible, since warranty laws are often difficult to understand.

5. New York General Business Law, Article 35: Warranties on Mobile Homes.

Often the elderly put much of their life savings into a mobile home upon retirement. This law provides that any defects in the mobile home are the responsibility of the seller for the first year after sale. Advise the elderly person to notify the dealer or manufacturer in writing immediately upon notice of the defect.

6. New York Real Property Law, Article 9-B: Condominium Act.

Every year, thousands of elderly persons sell their homes and purchase condominiums as a place of retirement. The sale of condominiums is highly regulated by both state and federal securities laws and real estate laws. Offerings made within New York State must be filed with the Attorney General and approved as to form, but not substance. Assuming that the elderly persons who is in a financial position to purchase a condominium will be able to afford counsel, your only responsibility as a professional is to advise him of the importance of retaining counsel for such a purchase. Otherwise, his life savings may be used to purchase one-quarter acre of swamp in Florida.

This list is meant to be a brief survey of consumer protection laws for the elderly. It is by no means exhaustive. Other statutes exist which regulate home improvements, the sales of hearing aids, etc., which are vital to protect an elderly person in the marketplace. The instructors may wish to locate other laws for discussion in the classroom.

IV. Social Security and Social Welfare Programs

A. Overview

The number of social benefits available to older Americans, and the complexities of obtaining, keeping, and/or modifying them make impossible a comprehensive review and discussion here. This outline will attempt to list the bare bones about the programs and their eligibility requirements, and refer the student to agencies and other sources that can provide more comprehensive information.

In this area of concern, older Americans generally have three sorts of problems. The first is a basic lack of information. A layperson working with older Americans can often answer many questions. Sufficient knowledge can be gleaned from agency publications, newspaper articles, handbooks and the like to answer these general questions: How old must I be before I can apply for Social Security? How do I obtain my husband's death benefit? Is there any subsidized housing available?

The second type of problem arises when an older person presents a specific problem, often arising some time after the initial contact with the agency. Answers to these specific problems require expertise, and many of them require the expertise of an attorney. By handling many of these problems, one can develop the ability to sort out those that need an attorney's aid.

The third problem area is getting an agency to expedite an application or solve a problem. For example, certain documents are needed when applying for Social Security survivor's benefits. Often, the agencies will speed processing if they know someone is helping the applicant or recipient and is keeping track of the agency's actions.

The generally applicable rule is that anyone can aid or represent an older person before the agencies. In many situations, no special ability is needed. However, in some cases the aid of an attorney is advised. As noted above, experience is the only way to know when technical advice is warranted. However, if in doubt, contact an attorney or legal aid organization.

Do not hesitate to contact elected representatives for help, especially the appropriate Congressman. A congressional office can provide a great deal of information, and commands instant attention from federal, state, and local agencies, since the vast majority of their funding comes from the federal government.

The agencies can provide much information. Pamphlets on various aspects of programs are available, and many agencies will provide speakers to describe their programs and answer questions. All of the agencies have handbooks and manuals that regulate their conduct. Publications such as the Code of Federal Regulations, and the New York Codes, Rules, and Regulations are available to the public. Access to the agencies' manuals can be very difficult, even though there may exist a right to access. This is an unsolved problem. However, the development of a good relationship with the agency can help alleviate that problem.

There are several commercially published works that are useful summaries on the rights of the elderly. However, because of the number, scope, and complexity of Social Security, and other social welfare programs, there is no definitive summary that can substitute for personal experience.

UNIT SIX - B

B. Outline of Programs

The following is a brief outline of Social Security and other programs available to older Americans. The outline is not exhaustive. If one has contact with a person who has a problem that is not covered by these programs, it is quite likely that there is an appropriate public or private program available. Contact the local Social Security office, Red Cross or other volunteer center, chapter of the American Association of Retired Persons or Congressional office.

1. Social Security

   a. Administered by the federal Social Security Administration of the Department of Health, Education and Welfare.

   b. Programs

      1) Retirement benefits.

         a) Eligibility depends on the interplay of a number of factors.

            i. Age at application.

            ii. How many quarters a person was employed in a covered occupation.

            iii. Income.

         b) Benefit level depends on many of the same factors as eligibility.

         c) Determination of eligibility, and resultant benefit level is an individual process.

      2) Survivor's benefits.

         a) Eligibility and benefit level depends on eligibility and benefit level of the deceased.

      3) Disability benefits.

         a) Eligibility depends on not being able to work at anything, as well as how many covered quarters a person has.

         b) Benefit level will depend on factors similar to those determining eligibility.

2. Medicare (See following Section C, for more detailed information on Medicare and Medicaid.)

   a. A health insurance program set up under social security, administered by the Social Security Administration and regional carriers, for people over 65 years and many severely disabled people under 65.

b. Programs

1) Health Insurance

a) Eligibility

i. Automatic coverage based on number of quarters employed, or
ii. Monthly premiums.

b) Benefits

i. Hospital services up to maximum of covered services,
ii. Nursing home services up to maximum of covered services,
iii. Many other health services are covered.

2) Medical insurance

a) Eligibility is based on a monthly premium.

b) Benefits

i. Doctor's services	X		
ii. Emergenvy room bills	X		up to 80%
iii. X-rays		X	after
iv. Prosthetic devices	X		deductible
v. Other	X		

3. Medicaid (see Section D for more details)

a. Administered by local Dept. of Social Services.

b. Eligibility is based on economic need as assessed by state devised criteria. These criteria are subject to frequent change.

c. Almost every needed medical service for an eligible person is covered by Medicaid.

4. Supplemental Security Income (SSI)

a. Jointly administered by Social Security Administration, and State Departments of Social Services.

b. Eligibility: aged, blind, and disabled persons not eligible for other income assistance programs, who have less than a maximum of resources. Criteria do change.

c. Benefit level: federal minimum that states have the option of supplementing, depends on many factors, and has been changed several times since program was instituted.

5. Housing (see Section V, Housing Rights, for more details)

a. There are several Federally subsidized housing programs.

b. Basically they provide housing for needy elderly persons on a subsidized rent basis.

c. Long waiting periods before an applicant can gain admission are common.

d. Contact local housing authority for details of housing programs for aged persons in a specific community.

6. Nutrition

a. Federal funds are available to set up two programs that provide subsidized meals.

1) Meals-on-Wheels, which brings hot meals to elderly persons confined to their homes.

2) Hot meals at central locations to which the elderly come under their own power.

b. Contact State Administration or Department on Aging in regard to availability of funds under the 1972 National Nutrition for the Elderly Act.

7. Taxes

a. Federal

1) Extra personal exemption for persons 65 yrs. or older.

2) Credits on retirement annuities.

3) Medical deductions.

b. State and local

1) Many states and localities reduce or forego property taxes on property owned by persons over the age of 65.

8. Volunteer Programs

a. Action

1) Foster Grandparents

2) Retired Senior Volunteer Program

3) Service Corps of Retired Executives

4) Volunteers in Service to America

Compensation for Action programs ranges from nothing to lunch and travel expenses.

b. U.S. Department of Labor

1) Operation Mainstream

A program designed to pay needy people to do work that improves the communities in which they live. 40% of the participants must be 55 years of age or older.

Contact the local offices of ACTION, and the Department of Labor for information on what programs are operating, or can be started in your community.

C. Medicare

This is a federal health insurance program designed to pay for some items of medical care for certain groups of elderly persons. Medicare is operated by the Social Security Administration. The program is divided into two parts: Part A payments to medical facilities and Part B payments to persons performing services.

Persons eligible for Part A benefits include all persons 65 years of age or older and persons entitled to receive disability benefits from the Social Security or railroad retiremetn programs. Eligibility has nothing to do with financial resources.

Part A services include in-patient hospital services, in-patient care in a skilled nursing facility and home health services. Payments are restricted to a benefit period and recipients may have to pay a hospital deductible. A utilization review committee of the hospital or nursing facility must approve one's stay. Home health services under Part A also have some restrictions.

Part B benefit eligibility is the same as for Part A and Part A recipients are automatically enrolled. Premiums are paid as established by the Secretary of Health, Education and Welfare. Services provided include most physician, nursing and technical services, subject to an initial deductible and an 80% total limitation.

Services under either Part A or Part B are only paid when rendered by providers of medical assistance enrolled with the Social Security Administration. The provider directly bills the Social Security Administration under Part A or the cooperating insurance carrier under the latter plan. Appeal is allowed solely from decisions affecting entitlement to benefits or the amount of actual benefits paid. Procedures for appeal have been established by the Social Security Administration.

Resources:

A local Social Security Office is the best resource, but for additional information, consult Title #42 of the United States Code, Section #1395. See also volume #20 of the Code of Federal Regulations, Section #405.

"Materials on the Rights of the Elderly" - assembled by the Syracuse University Center for Legal Services for the Aging - (May, 1975) - for the New York State Office for the Aging and available through that office.

D. Medicaid

The federal Medicaid program was enacted into law in 1965 as Title XIX of the Social Security Act. It is a federal/State medical assistance program for the poor, which compensates directly the "providers" of medical care to the needy. Unlike Medicare, it is not an insurance program and recipients are under no obligation to pay for services.

Application is made through a local office of the State Department of Social Services. A fair hearing to determine eligibility is available upon denial. Eligibility is open to several categories or needy persons, including AFDC recipients, Home Relief recipients or eligibles' children receiving care under the State Social Services Law, and generally the aged, blind and disabled. Appropriate Social Security, AFDC or state supplement income standards apply but an individual determination based on need is made in each case. Persons with incomes above Medicaid eligibility could become eligible by a reduction in income due to medical expenses such as in cases of catastrophic illness.

Recipients are entitled to their free choice of qualified providers. Most necessary medical expenses are covered subject to the limitations on amount and duration established by the State Social Services law.

Resources

The best source of information is the local office of the Department of Social Services, but see also the following:

- "Materials on the Rights of the Elderly", assembled by the Syracuse University Center for Legal Services for the Aging. (May, 1975)
- Title XIX of the Social Security Act found in Volume #42 of the United States Code, beginning with Section #1396. The federal regulations may be found in Volume #45 of the Code of Federal Regulations, Sections 248 to 250.
- The applicable New York State statute may be found in Title II of the Social Services Law, Sections #363 to 369. The applicable regulations may be found in Volume #18 of the New York Code of Rules and Regulations, part #360.

V. Housing Rights of the Elderly

A. Non-Institutional Rights

The purpose of this section is to familiarize the reader with the basic housing rights of the elderly. The first section deals with non-institutional rights; institutional settings are dealt with separately.

The housing rights and problems of elderly persons are essentially the same as those of poor people; therefore, they are treated together except where legal circumstances affect elderly persons especially.

Because so many elderly persons are influenced in their housing needs by federal housing programs, a brief discussion of the basics of these programs is useful. This is followed by a look at rights created through the landlord-tenant relationship. Finally, the legal rights of the elderly home-owners are addressed.

1. Federal Housing Programs

Public housing was first established in 1937. Since that time, a number of developments have led to what is now a diversified and reasonably comprehensive federal housing program. The more important of the housing schemes will be described briefly, to familiarize the reader with the kinds of legal relationships formed when persons reside in federally assisted housing.

a. Conventional Public Housing

The main ingredient of the federal programs is money. Under conventional public housing, reliance is placed upon local public housing agencies, through which federal assistance is channeled. The local agency initiates a housing proposal, designs the project, acquires the site, and is responsible for construction and administration of the project, all within federal guidelines. The Department of Housing and Urban Development (H.U.D.) executes an Annual Contributions Contract, under which it pays a large part of the project's costs, and secures the local agency's bond issues. The bonds are exempt from federal taxes; and, thus may be marketed at a low yield. The project must either be exempt from property taxes, or receive local contributions equivalent to the tax remission. These various money mechanisms facilitate the low-rent character of the project.

Some of the more significant requirements placed on the local agency's follow:

1) With few exceptions, the local government must eliminate (through repair or demolition) the same number of unsafe or unsanitary dwelling units as there are new units created by the project.

2) Families displaced by a project must be offered relocation and relocation payments.

3) There must be a 20% gap between the upper rental limits of the project and the lowest rents at which the private market is providing a substantial supply of decent housing.

4) Rents must be low enough for families of low income, and may not exceed 25% of the family's income.

5) Families must be admitted to the project consistent with income levels; if a family's income increases such that private market housing becomes accessible, the family must leave the project.

Although H.U.D. generally disapproves of high rise projects, an exception to this policy is made in the case of housing designed for occupancy by the elderly. This is because elderly persons are often less ambulatory than other project residents, and benefit from the shorter distances in high-rise structures. Also, the centralization inherent in these structures facilitates the provision of services to the residents.

b. Variational Public Housing - Turnkey I

The major feature of the "Turnkey I" variation in public housing is the use of private developers. A local agency invites proposals from these developers, and selects the most desirable proposal (again, within federal guidelines). The developer then constructs the project and sells the finished project to the local agency. The local agency receives the same basic funding assistance from the federal government as is present under the conventional public housing program. The same requirements apply as to elimination of unsafe and unsanitary housing, relocation of displaced families, and rental rates.

By utilizing private developers, the local agencies receive the benefit of the efficiency of the competitive private market. As a safeguard against "over-efficiency," H.U.D. has established various design and construction standards. The ability of local community groups to work with developers and participate in project planning is another, and potentially more significant advantage of the Turnkey I program.

c. Another Variation - Leased Housing

Under the standard leasing program, local public housing agencies lease existing housing units from private owners, and re-let the units to low-income tenants. Because the local agencies receive Annual Contributions Contract subsidies, all of the statutory requirements of conventional public housing apply.

In a variation on this theme, the "Section 23" leasing program, the normal "cooperation agreement" with the local government is eliminated. Thus, there is no remission of local property taxes; and, also, minimal local government interference with project goals. Another facet of Section 23 leasing is the elimination of the requirement for demonstrating a 20% gap between the highest public housing rents and the lowest rentals available in the private market.

There are both advantages and disadvantages to the leasing programs.

Advantages include:

1) The processing time is shorter, because there is no need to wait for construction.

2) Housing units may be dispersed throughout the community; this offers anonymity regarding the subsidized nature of the housing, thereby lessening social tensions and encouraging more positive tenant attitudes.

3) There are no restrictions as to types of structures.

4) The owners of leased structures are entitled to favorable tax-depreciation methods.

5) The owners avoid the loss of income through vacancy, as the public housing agency is the leaseholder.

6) The leases must contain anti-discrimination provisions, and warranties of "no local code violation."

7) In section 23 leasing there is no requirement for maintaining a 20% rental gap.

8) Leased-unit families whose income increases may avoid leaving by assuming the lease.

Disadvantages of the leasing programs include:

1) Because the units are widely dispersed, the provision of tenant services becomes more difficult.

2) Control and supervision of tenants decreases.

3) Local administration tends to disfavor poverty tenants.

4) Leased housing is more expensive, because of higher administrative costs and the loss of the local property remission.

d. Other Public Housing Schemes

Numerous other types of public housing exist. The "Section 236" program, for example, incorporates non-profit private sponsors to initiate, plan, develop, finance, and manage the project. Public agencies are not eligible. The United States Housing Authority, through H.U.D., offers liberal financing terms and federal income tax benefits. The rent charged is 25% of the tenant's dependent-adjusted income. There are rental ceilings and floors based on the subsidized debt service on the mortgage. Eligible families are those whose incomes are within the "lowest practicable limits." Admission preference is given to families displaced by urban renewal, other governmental action, and national disaster. The private mortgagor manages the project, subject to a regulatory agreement with H.U.D. The Section 236 program may be combined with Section 23 leasing (see above).

Other programs provide for low-income families to purchase their low-rent housing, but these schemes are generally impractical for elderly persons.

e. Housing Rehabilitation

Public assistance for housing rehabilitation is limited. Generally, the existing programs are oriented to rehabilitate urban renewal areas, and provide no assistance to the low-income owner-occupant in a deteriorating dwelling outside an urban renewal designated area. Within designated areas, however, both loan and grant programs, when funded, exist. They are, however, generally limited to large scale developers. H.U.D. offers insurance programs for home-improvement loans, but these programs are not subsidized.

Rural families of low income (below $5,000 per year) may receive "Section 502" loans from the Farmers Home Association, if they can demonstrate inability to receive financing from other sources. These loans, at low interest rates, may be used for approved rehabilitation and for certain construction. Small loans are also available under "Section 504".

To conclude the sub-section on federal housing programs, certain general rights need to be enumerated.

Public housing agencies are required to promptly notify applicants who are found ineligible for housing on the basis of the determination. The agencies must also provide, upon request, an opportunity for an informal hearing on the determination. Applicants determined to be eligible must be advised of the approximate date of occupancy. Similarly, evictions from federally sponsored housing generally require hearings, as a matter of constitutional "due process." Evictions for "dangerousness" or "undesirability" must not be based on arbitrary decisions, and, of course, are subject to court rulings if contested. The rights of tenants in public housing to hearings on questions of rent increases, building maintenance problems, security, and imposition of fines, are presently undecided; however, there is a trend toward the granting of hearings.

2. The Landlord-Tenant Relationship

Only recently have courts begun to moderate the traditional "caveat emptor" doctrine applicable to tenants in housing. Though many inroads have been made, only the most significant can be enumerated here.

a. Constructive Eviction

In residential leases, a "covenant of quiet enjoyment" is implied. This means that the tenant is guaranteed the beneficial use of the premises as a residence. If the landlord breaches this covenant, the tenant may sue for money damages or for an injunction. If the landlord's interference is substantial, the tenant may treat the action as an eviction. However, the tenant must then leave the premises to avoid the duty of paying rent. This "remedy" is largely unsatisfactory.

Courts are beginning to recognize a doctrine of "partial constructive eviction," under which the tenant may remain in the premises while with-holding at least a part of the rent.

b. Warranty or Habitability

As a parallel development, courts increasingly adhere to an "implied warranty of habitability" in residential leases. With this approach, a tenant may remain in possession of the premises and assert a "breach of warranty" in an action for non-payment of rent. In some jurisdictions, it has been held that a tenant may even make repairs needed for habitability and deduct their cost from the rent, but only after the landlord has had a reasonable time to make the repairs himself.

c. Landlord Liability for Safety and Security

Landlords have been held liable for negligence in cases where they knew, or should have known, of dangerous housing conditions which they did nothing to alter. Local housing codes have been found to establish a "standard of care," and major violations which result in injury often create a presumption of the landlord's liability.

The law seems to be gravitating toward landlord liability for failure to provide protective service, such as utilization of security guards, in high-crime areas. This doctrine will include low-income housing developments, wherein public agencies, as landlords, may be liable for crime-related losses and injuries. The law is still unsettled on this point.

d. Retaliatory Eviction

Often, a landlord attempts to evict a tenant as a means of retaliation to the tenant's efforts to invoke legal claims respecting living conditions. Evidence that an eviction is retaliatory is a defense against a landlord's action for possession of the premises.

3. Elderly Homeowners

The legal rights of elderly homeowners vary little from the rights of all homeowners.

a. Basic Purchaser's Protections

Elderly persons who purchase homes receive fundamental protections against fraud and misrepresentation on the part of agents, brokers, and sellers; but, in home purchasing, the doctrine of "caveat emptor" still largely applies. It is recommended, therefore, that home buyers be represented by their own attorney (not the seller's attorney) prior to extending a purchase offer, and throughout the home buying process.

b. Tax Relief

One significant right granted to elderly homeowners in many jurisdictions is some form of property tax remission. In New York State, for example, elderly homeowners (65 and over) may receive an exemption from taxes on 50% of the assessed valuation of their real property if:

1) the exemption is applied for; and
2) the property is occupied by the owner; and
3) the property is exclusively residential; and
4) title has vested in the owner for at least five years prior to the exemption application; and
5) the owner's income does not exceed a limit of between $3,000 and $6,000, as set by local law.

However, there can be no school tax exemption if a child in residence attends a public school.

c. Disaster Relief

A federal right granted to the elderly homeowner relates to disaster relief loans. In the administration of any federal disaster loan program, the age of any adult loan applicant will not be considered in determining whether the loan should be made, or its amount.

d. Guardianship

In New York State, elderly property owners who are unable to conduct personal or business affairs may lose possession, use, and control of their property to a guardian. Title, however, remains in the owner's name.

4. Conclusion

The above information is far from comprehensive. It attempts only to broadly illustrate the basic housing rights and obligations of elderly persons. Much of the above information is paraphrased and condensed from an excellent text, Law of the Poor, by Arthur B. La France, Milton R. Schroeder, Robert W. Bennett, and William E. Boyd. The book is published by West Publishing Company. It is highly recommended, not only for its outstanding discussion, but also for its excellent bibliographic notes.

Other sources used include The Aged and the Need for Surrogate Management, by George J. Alexander and Travis H.D. Lewin; Title 14 of the United States Code Annotated; New York State Real Property Tax Law, Section 467; and, New York State Mental Hygiene Law, Sections 100 and 101. More detailed information about the subject areas above may be obtained by reference to these sources.

B. Public and Institutional Housing: Nursing Homes

1. Categories, ownership and regulation of nursing homes

Skilled nursing facilities provide 24-hour medical care under the direction of a registered nurse. Intermediate care facilities provide less comprehensive care but some medical and physical therapy and proprietary homes or domiciliary homes, provide only limited assistance with certain living tasks.

The classification of a nursing home is relevant to the government regulation under which it operates and to the patient's eligibility for government payments. HEW requires certain services such as rehabilitative programs if the skilled nursing facility (SNF) is to be reimbursed by Medicaid or Medicare. HEW also requires SNF's to comply with state regulations, with the regulations of various government levels regarding construction and sanitation, and with its own patients' bill of rights.

Intermediate care facilities (ICF's) are also governed by federal and state regulation.

In New York, SNF's and ICF's are regulated by the State Health Department and the State Hospital Code; proprietary homes are regulated by the State Board of Social Welfare.

Nursing homes are inspected to determine whether they meet government standards and regulations. Under Medicare and Medicaid, inspections are conducted by a state agency, either the agency designated, or an agency to which the designated agency has delegated responsibility. Certification will state whether the nursing home is in full compliance with the regulations, or in compliance but with deficiencies, or not in compliance. A facility in full compliance is said to have a "provider agreement" which is valid for a year. A facility in deficient compliance will be granted a reasonable time to meet standards, and will be eligible to receive reimbursement if the deficiencies are said not to affect adversely the welfare of the patients. A nursing home which deviates from the regulations so that it cannot render adequate care will not be certified.

Inspections for compliance with state standards are generally conducted simultaneously with inspections for compliance with federal standards. In New York, the State Health Department conducts inspections, and has also contracted with the County Health Departments of Erir, Monroe, Nassau, Suffolk counties to do inspections there.

There is some weight to the charge that nursing home inspections are ineffective. Inspection agencies are usually understaffed, and frequently will be loath to find a facility out of compliance for fear that the home will not receive reimbursement and the Medicare and Medicaid patients may be transferred. Furthermore, nursing homes are often notified in advance of inspections, although HEW is now discouraging advance notice. The New York Health Department recently announced that it will no longer give advance notice.

Information regarding nursing home inspections, and the inspection reports themselves, are now recognized to be open to the public. The reports should be available within ninety days after inspection to anyone who requests them at State Health Department Offices at the District Offices of the Social Security Administration for Medicare homes, and at local Department of Social Services Offices for Medicaid homes. Some state personnel are still reluctant to divulge this information. They should be reminded of the Freedom of Information Act, which permits full disclosure of almost all government information, and of the case Stretch vs. Weinberger, in which a federal district court found the Act applicable to HEW.

Most nursing homes are privately controlled and most are operating for profit. Recent investigations indicate that a few organizations or individuals in any one area may control a large number of facilities.

2. Costs

The cost of nursing home care may vary from $200 to $1200 a month. Skilled nursing facilities often charge about $1000 a month. "Additional" services such as feeding may increase the total cost. Prior to deciding on a nursing home, the patient or someone responsible should request a written list of "extra" charges. The federal patients' rights acts and the New York State Hospital Code require disclosure of costs. Costs data which would not invade the privacy of a particular individual is open to the public.

3. Entering a Nursing Home

In visiting a nursing home, one should talk to the patients, inquire about the level of care, and also note the alertness

and grooming of the patients, for these qualities often relate to the attitude of the staff and the level of care. Townsend's Old Age: The Last Segregation (1971), includes a list of questions to ask during the visit. State inspection reports and the advice of local advocate and volunteer groups are also useful. The following questions should be considered. Does each patient have enough space and privacy? Is the home in a good location near friends and cultural events? How strict is the home regarding drinking and visitors?

Medicare will pay for the elderly in a skilled nursing facility, if the individual is certified as needing such care. Medicaid will pay for several types of care if the patient is considered poor enough.

4. Alternatives to a Nursing Home

Medicare and Medicaid both provide payment for health care services at home. It may be difficult to qualify or to obtain the desired level of care, but it's worth trying.

5. Living in a Nursing Home

The federal patient's bill of rights provides that nursing home patients have the right either to manage their own finances or to receive a quarterly accounting; the right to see a physician periodically; the right not to be transferred except for medical reasons or for nonpayment; the right not to work for a nursing home unless the work is of a therapeutic nature; the right to complain about conditions without reprisal; the right to plan their treatment; the right to refuse drugs or restraints; and many other personal rights. Since many of these rights are open to interpretation, for instance "therapeutic work," and since the bill of rights lacks adequate enforcement procedures, patients and patient advocate groups should be alert to assert and protect these rights.

"Life-care" contracts, which require the patient to turn over all his assets to the nursing home in exchange for a promise of life-time care, thus depriving the patient of the power to bargain or to change his mind, are usually recognized to be undesirable. In New York they are illegal. A patient is free to leave a nursing home whenever he wishes. Coercion is grounds for a suit for false imprisonment. If the patient desires to continue receiving care but merely wishes to make a number of trips home, however, he may run up against Medicare and Medicaid provisions limiting the number of home visits. These provisions were designed in part to prevent the fraudulent reception of payment by nursing homes, but unfortunately they may restrict the freedom of patients.

6. Action of Advocacy and Volunteer Groups

Since the patient in a nursing home is in a poor position to assert and protect his rights, advocacy groups should keep themselves informed of conditions in nursing homes. They can act as grievance committees, and they can pressure officials into action and bring suit.

7. References

Syracuse University Center for Legal Services for the Aging, Materials on the Rights of the Elderly, May, 1975. Contains extensive bibliography.

Thomas, Nursing Homes and Public Policy. Cornell Press, 1969.

Cohen, William. Nursing Home Patients' Bill of Rights. Congressional Record, Vol. 121, No. 7, January 23, 1974.

National Senior Citizens Law Center, 1709 West 8th St., Suite 600, Los Angeles, CA 90017. 13-483-3990. Various materials on private and public housing issues, particularly a Nursing Home Handbook.

Mendelsohn, Tender Loving Greed, 1971

Dog-gone Curbs. Write 722 Capitol Mall, Sacramento, California.

8. Guides to Sources

Current Literature on Aging, National Council on the Aging, Inc. (quarterly bibliography).

Shock, N.W. A Classified Bibliography of Gerontology and Geriatrics. Stanford University Press. 1963. Plus supplements.

VI. Instructional Strategies

1. Suggested Films

"The Health Fraud Racket" describes how worthless and dangerous remedies and "therapeutic devices' are promoted to the public and suggest ways in which the consumer can guard against such deception.

Available:

National Medical Audiovisual Center (ANNEX)
Station K
Atlanta, Georgia 30324

"The Big Con" describes a couple who are talked into buying a worthless product which blows up and leaves them with a thick payment book. Also outlines pitfalls of consumer buying.

Available:

Attorney General's Office
217 West First Street
Los Angeles, California 90012

"Inside and Outside" depicts the differences in the lives of older people inside and outside institutions.

Available:

Special Materials Division
Main Library
North Texas State University
Denton, Texas 76203 (817) 788-2411

"Seasons" deals with the health and rehabilitation of older people. It covers the topics of nursing home conditions and effective programs in geriatric therapy.

Available:

General Services
National Archives and Records
National Audiovisual Center
Washington, DC 20409

or

New York State Office for the Aging
Agency Building 2
Empire State Plaza
Albany, New York 12223

2. Readings and Group Discussion

Tying into other units, students might discuss life experiences they've had or know about concerning consumer issues and relate this to what they've learned about the aging individual and his vulnerability to these problems.

Invite a guest speaker from a legal aid center or social services agency to address the topic of protective services.

Discuss the implications of protective services on the individual, the family and the larger community. Relate the discussion to personal insights of the student regarding his aging process and family relationships.

Arrange a site visit to a nursing home and observe such things as the care of patients, the atmosphere of the home, the opportunities for privacy, adequate space for personal belongings, the amount of individualism that is allowed for within the environment.

Arrange for a nursing home administrator to speak to the class and have student prepare questions concerning patient freedoms and rights within the nursing home setting.

3. Securing Legal Services

Student project: To locate the nearest source of legal services in the community, find out how an older person can qualify for these services and what type of help is available and accessible.

VII. Evaluation

1. If it is the desire of the instructor, questions could be designed using the objectives listed at the beginning of this section.

2. Students might be asked to prepare a short paper on some aspect of legal problems included with this section.

3. A short proposal might be developed for new legislation or the revision of existing laws to better protect the rights of older persons. This could be an individual or small group endeavor and would serve to evaluate the student's knowledge of the topic and his grasp of its implications.

VIII. Bibliography

Atchley, Robert C. The Social Forces in Later Life. Wadsworth Publishing Co., Inc., Belmont, CA., 1972. Chapter 14 "Economy", "Older Persons as Consumers," p 231-236. This chapter offers some insight into the problems of the aging consumer.

Manney, James D., Jr. Aging in American Society, The Institute of Gerontology, University of Michigan, Wayne State University, Ann Arbor, 1975. Chapter 13, "The Law and the Older Person." It outlines the major issues involved in legal problems of the elderly, including consumer issues, competency, crimes against older people, etc.

Toward a National Policy on Aging, 1971 White House Conference on Aging, Vol. II, Special Concerns Session Recommendations: "The Elderly Consumer" and "Legal Aid and the Urban Aged," pp 225-236. This resource outlines the priorities of the elderly concerning legal issues.

Butler, "Why are Older Consumers So Susceptible?" Geriatrics, December, 1968.

Alexander, George and Travis D. Lewin, The Aged and the Need for Surrogate Management. Syracuse, N.Y., 1972. Chapter 2, "Determination of Incompetency," pp 15-27. Also, other topics covered in this book are Conservatorship (p 102), Roles of Committees (pp 112-117), and Restoration of Competency (pp 125-132).

Materials on the Rights of the Elderly, Assembled by Syracuse University Center for Legal Services for the Aging and Syracuse University All-University Gerontology Center, May, 1975. Copies of this book should be available for use in this course through the New York State Office for the Aging. This is a very useful source covering all the issues handled in this section. It also contains an extensive bibliography on the legal concerns of the elderly.

Your Retirement Legal Guide, American Association of Retired Persons and National Retired Teachers Association, Long Beach, CA., 1971. This and other booklets published by AARP/NRTA provide advice to older persons concerning consumer and other legal affairs.

IX. Secondary Resources

Consumer Publications of the Senate Special Committee on Aging

Frauds and Deceptions Affecting the Elderly - Investigations, Findings and Recommendations. Committee print report, December, 1964.

Legal Problems Affecting Older Americans. A Working Paper, Committee Print, August, 1970.

Materials available from the New York State Office for the Aging:

Community Service Society of New York. 1973 Consumer Protection Legislation in New York State. Special Committee on Consumer Protection, Department of Public Affairs, 1973, p 17.

New York State Consumer Protection Board. Consumer Protection, 1973.

U.S. Department of Health, Education and Welfare. Food and Drug Administration. Office of Consumer Affairs. Consumer Guide for Senior Citizens. (FDA) 72-1008, 1971.

U.S. Senate. Special Committee on Aging. Consumer Interests of the Elderly. Washington, D.C., 1967. Parts 1 & 2.

Margolius, Sidney. The Aging Consumer. Ann Arbor, Institute of Gerontology, University of Michigan, 1969.

Blenkner, Margaret, Service and Survival. Paper presented at the 8th International Congress of Gerontology, Washington, D.C., August 26, 1969. Cleveland, Ohio, Benjamin Rose Institute, 1969, p 15.

Hemmy, Mary L., and Farrar, Marcella S. "Protective Service for Older People," Social Casework, Vol. 42, No. 1, January, 1962, pp 16-20.

Kalish, Richard A. (Ed.), The Dependencies of Old People. Occasional Papers on Gerontology, No. 6, Ann Arbor, Institute of Gerontology, University of Michigan, Wayne State University, 1969.

National Council on the Aging. Overcoming Barriers to Protective Services for the Aged. Report of a National Institute on Protective Services, Houston, Texas, January, 1968, Washington, D.C., National Council on the Aging, 1968. p 129.

Report on the Colloquium on Conservatorship. Sponsored by the New York City Office for the Aging and the Community Service Society of New York, 1973.

UNIT SIX - B

National Council of Senior Citizens, Inc., Legal Research and Services for the Elderly. A Handbook of Model State Statutes. Washington, D.C. National Council of Senior Citizens, Inc., 1971.

Wasser, Edna. "Responsibility, Self-Determination, and Authority in Casework Protection of Older Persons," Social Casework, Vol. 42, Nos. 5-6, May-June, 1961.

UNIT SIX

SECTION - C

DEATH AND DYING

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UNIT SIX

SECTION - C

DEATH AND DYING

I. Introduction

As one ages, one faces an increasing probability that he/she may not survive another year. Death, then is a very real fact of life for the older person. It is a factor in the conscious experience of aging. It underlies many of the anxieties and defenses that may accompany growing old. It will touch the lives of those who work with the aged - frequently and painfully.

We live in a death-denying society. Death has been banished to the confines of institutions. Professionals are required to "take care of" death; i.e., the funeral director, the physicians, the nurse, the social worker, the long-term care administrator. They have been given the responsibilities, but little preparation.

The student of gerontology must come to grips with death and dying for a number of reasons: to understand this important aspect of the experience of many older persons, to assist rather than abandon the older person who must face death, and, most importantly perhaps, to come to grips with his/her own mortality and the relationship between the meaning of one's own death and the meaning of one's life.

A unit on death and dying, if brief, should deal directly with the feelings and attitudes related to death. Facts may become appropriate only after a readiness has been created for such content. (By way of encouragement, I have found that teaching and learning experiences in topics related to death and dying have been among the most exciting, profound, and satisfying in my teaching career. They have proven to be anything but morbid or depressing.) The topic of death and dying, at present, is dominated by unresolved issues - personal, moral, legal, ethical and, to a lesser extent, theoretical. Thus, the instructor's role in this unit may be more profitably geared to facilitating an open, active, and personalized examination of the issues thus enabling students to engage and personalize these issues. Content, per se (i.e., theory and research), will be helpful in this process, but should perhaps be offered as an aid to understanding rather than a desired end product in itself.

II. Specific Objectives for this Unit

A. An understanding of the impact of advanced age on the older persons perspectives regarding his personal past and future.

B. An appreciation and respect for the fundamental unity and continuity of the human life cycle, including a positive awareness of issues relating to mortality and death.

C. An awareness and appreciation of the learner's own aging process and its implications for his personal future.

D. An understanding of views and institutional practices concerning death in American society.

E. An identification and understanding of principal issues and attitudes toward death among the elderly and characteristics of quality terminal care.

III. Specific Topics and Issues

Many of the topics appropriate to a study of death and dying require that a value judgement be made. Therefore, some of the topics outlined below will be presented in terms of questions. The suggested readings can be used by both instructor and student in formulating their own answers.

A. Death in American Society:

1. Institutionalized manifestations of denial of death, the strong emphasis on youth, while death is hidden in institutions, cloaked in velvet, covered over with flowers, and avoided in consciousness and conversation.

2. The Business of Death - American funeral practices.

3. The sudden emergence of death in American consciousness since 1970 - in the media and in education. What are the causes and the consequences of this new awareness?

B. Attitudes toward death:

1. Can one accept death as a natural part of the life cycle? Can one deal with the terror posed by the prospect of dying?

2. Why should one talk about death, if at all? What are the consequences of facing death consciously? Of avoiding death?

C. The Elderly Face Death:

1. Many believe that the elderly are most fearful of death because it is nearer. Some evidence would suggest, however, that many elderly can accept or even look forward to the prospect of their own death.

2. Nursing homes are often viewed as "death houses" - Does institutionalization affect the older person's feelings toward death and/or one's personal future?

3. Erikson's concept of "Ego Integrity" and Butler's "Life Review" are closely linked to the prospect of death. Explore these concepts from the perspective of imminent death.

D. The Process of Dying:

What is the experience of dying? What changes, if any, occur in the dying person's psychological organizations and orientation to the external environment?

1. Distance from death (See Lieberman's paper in Neugarten, Middle Age and Aging.)

2. The stages of dying. (See Kubler-Ross)

E. Technology and Death:

Man, with the aid of technology, has attained an unprecedented capability to greatly prolong life through respirators pacemakers, kidney dialysis. We now face the necessity of making a conscious choice - to prolong life or allow it to cease. We are totally unprepared to cope with such decisions, legally, morally, or medically. Who should make such decisions? How does one weigh the "quality" of life against the "quantity" of life?

F. Grief:

1. The nature of grief.

2. The importance of grief work.

3. Facilitating grief work.

G. Terminal Care:

How does one communicate with a dying person? Psychosocial dimensions of quality terminal care require the professional to come to grips with his own death-related anxieties and to listen to and understand the perspective and wishes of the dying person. That is, to develop the basic skills of empathy, genuineness, trust, respect and the readiness to invest oneself in the (profound) emotional struggles of someone else, someone who faces the loss of everything that has ever had meaning.

IV. Instructional Methods

A. Show films on death and dying, then discuss. (i.e., "What Man Shall Live and Not See Death?" - available from Concept-Media, Inc., CA.).

B. Describe the experience of the death of someone close. (Feelings, reactions of others, etc.)

C. Imagine the experience of death of someone close.

D. Imagine your own death.

1. Preferred time and manner of death.

2. Things that will be most missed? (Greatest losses)

3. Alone or with someone while dying. With whom would you choose to be? Why?

E. Administer, then discuss anxiety scales. (Montefiore, et. al., 1973).

F. Write your own will, epitaph, and eulogy - then discuss.

G. Bring in and discuss symbolisms of death in art, cartoons, popular music and popular literature.

H. Invite a panel of professionals - clergy, physician, nurse, social worker, funeral director to describe roles and experiences regarding death and dying in American society.

I. Deliver brief lectures followed by discussion (preferrably in small groups) and/or by other methods described above.

J. Interview staff in nursing homes to determine how death is handled.

K. Attend a funeral.

L. Debate the questions:

1. Under what conditions should life be prolonged by extraordinary measures?

2. Who should make such decisions?

V. Bibliography

Busse, E.W. and Pfeiffer, E. Behavior and Adaptation in Later Life. Boston: Little, Brown and Co., 1969, pp 183-182.

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Kastenbaum, R. and Aisenberg, Ruth. The Psychology of Death. New York: Springer, 1972.

Kimmel, D.C. Adulthood and Aging. New York: John Wiley and Sons, 1974.

Kubler-Ross, Elizabeth. On Death and Dying. New York: Macmillan, 1969.

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Neugarten, Bernice. Middle Age and Aging. Chicago: University of Chicago Press, 1968, pp 479-542.

Tolstoi, Leo. The Death of Ivan Ilytch and Other Stories. New York: Signet, 1960.

UNIT SIX

SECTION - D

NEW ROLES FOR THE AGING

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UNIT SIX

SECTION - D

NEW ROLES FOR THE AGING

I. Introduction

This section is designed to provide information about roles and activities that offer options to improve the quality of life for the aged. In our industrial society, role loss has become a dominant theme for older people as they retire from the economic role and/or lose their significant familial roles when children leave the family. These role losses are significant. If they are not replaced, this situation could last for as long as 30 years. The government has made efforts to provide such basic services as income, health, services and low income housing. Until recently, however, it had not begun to provide opportunities for the elderly to feel needed and to fill useful roles in society. Older persons are beginning to find new roles for themselves as they become involved politically in issues that affect their lives, fight job discrimination, and grow in interaction with others, both recreationally and as volunteers. The elderly need more options for new roles that give meaning to their lives and to the community in which they live.

II. Statement of Objectives

The following objectives are based on the need of the student for information about optional roles and activities to improve the quality of life for the aged.

A. Affective Objectives

The student should develop:

1. An awareness and appreciation of changing roles in aging and in one's own life as the result of retirement and the empty nest syndrome.

2. An awareness of cultural beliefs that act as restraints for new roles (for example: leisure, considered worthless in our "work oriented culture"; work, older people not "able" to do job).

See also Chapter One, Affective Objectives, Nos. 1, 4, 5, 9, 10, 11, and 12.

B. Cognitive Objectives

The student should be able to:

1. Describe the importance of the concept of "role."
2. Describe the process of terminating one role and the transition to and preparation for new roles.
3. Describe the theory of "developmental tasks."
4. Describe new roles for the aged:
   a. Political action
   b. Community service
   c. Education
   d. Employment
   e. Leisure
   f. Resource to others
   g. New, emerging roles

See also course objectives listed in Chapter One under Cognitive Objectives, Nos. 7, 8, 9, and 10.

III. Role Loss

The life cycle of every human being begins with birth and ends with death. That is an accepted fact of nature. However, the quality of life is determined not only by the biological processes within each individual, but also by the culture within which the person lives.

Simone DeBeauvoir in The Coming of Age describes how the aging are treated in the industrial Western culture. Man, in his last stage, is a throw-away commodity, a do-nothing faced with a suspended death sentence. Society forces retirement which, in turn, forces a low income, poor living conditions, and a life of boredom and loneliness. The elderly are made to feel that they are a burden to the working segment of the population.

Sharon Curtin also describes the condition of the American aging. Her book, Nobody Ever Died of Old Age, won a notable book award in 1973 for significant contribution to knowledge. Her vignettes describe the destruction of the aged by discrimination, isolation and oppression. Rapid social change has created problems such as the increasing emphasis on the nuclear

family, on economic goals that force early retirement and on social values that equate a person with a job. She also describes rather caustically those with control over the lives of older people. Suitable activities are arranged and husband and wife are separated "for the good" of the individual older person.

In an article in Atlantic Monthly, Ms. Curtain stated: "The aged live with enforced leisure on a low income, subject to many chronic illnesses, and most of their money goes to keep a roof over their heads. They also live in a culture that worships youth, that makes us think the young are best and treats old people like outcasts."

In this country, life expectancy has lengthened due to medical advances. Thus, people can postpone the confrontation with death. Instead, many fear the twenty or so years after they retire or when they are no longer needed as parents. This fear can be traced to the absence of significant roles in older life. When life expectancy was short, people still performed significant social roles throughout the life span. Then they feared the prospect of death. Now they fear old age.

A middle-age person fears old age since it may mean abandoning such familiar roles as parent, spouse and worker. A spouse may die, children may leave the nest and forced retirement may eliminate the work role. These roles provide patterns of living as well as a source of recognition within the community. When loss of these roles occurs, what will replace them?

The preparation and replacement of roles should be a part of planning for later life. Society should provide new roles for the aging. As Dr. Robert Butler said: "We need to enhance the reality and sense of personal growth throughout the course of life - until the very end."

Role loss and role exit can be rectified by the process of role replacement: the substitution of new roles to replace important roles that have been lost. There is often a period of anticipatory socialization or preparation for a new role, when expectations associated with the new role are explored. This involves practice or trying out a new role before the actual transition is made. In this culture, an analogous situation is the use of the "engagement" period as a socialization time for the young couple about to be married. Similarly, in middle age, people may volunteer in jobs they might later pursue or attend school to further their education. In addition, there are pre-retirement courses formally designed to

prepare adults for life after 65. The middle-aged homemaker usually experiences role loss early when parenthood as an all-consuming activity gradually ends. Some middle-aged women solve this problem by seeking further education to prepare for interesting jobs. They have found new roles to replace that of homemaker. These are hopeful signs. Instead of worrying about the future, older persons are acquiring skills and knowledge to prepare themselves for new roles after 65.

IV. Application of Developmental Theory to Role Loss and New Roles for the Aging

The developmental process begins at conception and is orderly, sequential, cumulative and irreversible (see Units One and Two). The concept of development considers the years after 65 as a normal phase of the life-cycle with its own tasks to be mastered. The term "life cycle" implies a process of continual change as individuals master the new tasks required to adapt to new situations. Each new role involves some uncertainty. "What will it be like when I'm married? When I have a job? When I have a child? When I change my job? When I retire?"

Erik Erikson's developmental scheme conceived of human life as having eight stages, each of which had a task to be accomplished. The stage proposed for middle age is generactivity: "The concern of establishing and guiding the next generation to preserve the essentials of human community." The last stage was integrity: "The acceptance of one's life as one's own responsibility." Erikson's generactivity phase could and should be utilized in attempting to understand the experience of older people. The ego integrity stage might be a part of an older person's concern, but life for most older people should be more than a reflection on one's past experiences and accomplishments.

Robert C. Peck felt that Erikson's scheme was global and non-specific. He said older people have three definite tasks for their developmental stage:

1. To move to ego differentiation from work role preoccupation. The retiring person can take satisfaction in a broader range of role activities than just the long-time work role. "Am I worthwhile as a person, instead of worthwhile as an economic being or a parent?"

2. To move to body transcendence from body pre-occupation. Mental and social powers can increase with age though old age may be accompanied by a decline in resistance to illness.

3. To move to ego- transcendance from ego pre-occupation. Margaret Clark and Barbara Anderson conceptualized a set of adaptive tasks for successful aging. Their tasks were noteworthy because they took into consideration the social situation of the elderly. These tasks are to:

   a. Admit that aging involes limitations
   b. Change physical activities and social roles
   c. Find new ways to fulfill one's needs
   d. Develop new criteria for self evaluation
   e. Establish new values and goals for one's life

Dr. Robert Butler summed up the developmental concept by stating: "A continuing life-long concern with one's identity is a sign of good health and the right to have such a concern is one of the important rights of life."

V. Bibliography: Role Loss and Developmental Theory

Atchley, Robert C. The Social Forces in Later Life. Wadsworth, 1972.

Blau, Zena Smith. Old Age in a Changing Society. New View Points, 1973.

Butler, Robert. Why Survive? Harper and Row, 1975.

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Erikson, Erik. Identity, Youth and Crisis. Norton and Company, 1968.

Kimmel, Douglas K. Adulthood and Aging. Wiley and Sons, 1974.

Manney, James D., Jr. Aging in American Society. The Institute of Gerontology, 1975.

Peck, Robert. "Psychological Developments in the Second-Half of Life." In B.L. Neugarten (Ed.) Middle Age and Aging. The University of Chicago, 1968.

VI. Description of New Roles for the Aging

A. General Review

There are a variety of new roles for the aging being discussed in the literature and being promoted through social action. Of particular interest are the roles the older Americans can play in political action, community service, leisure, employment and continuing education as well as serving as role models for others.

1. References

Arthur, J. Retire to Action. Abington Press, 1969, pp 21-35.

Blau, Zena S. op. cit., "New Roles for Later Life," pp 176-208.

Hunter and Woodrow. Preparation for Retirement. Institute of Gerontology, 1973.

B. Involvement in the Political System

The term "senior citizen" was constructed as a euphemism for "older people." If this term indicated an opportunity to influence the passing of legislation that would affect their lives, it would also provide for older persons a sense of dignity in this youth-oriented culture. As a recent article in the New York Times pointed out, the elderly are organizing to become a new political power in this country. There are many groups within the elderly population that are interested in political action.

1. Programs

a. American Association of Retired Persons

Both the American Association of Retired Persons and the National Retired Teachers Association are alert to issues of concern to older persons. They work with members of Congress and the State Legislation and send information to local chapters of AARP.

For information write:

American Association of Retired Persons
215 Long Beach Boulevard
Long Beach, California 90801

b. Gray Panthers

The Gray Panthers
3700 Chestnut Street
Philadelphia, Pennsylvania

2. References

Annals of the American Academy of Political Science, September, 1974. The whole issue is devoted to the political consequences of aging.

Atchley, op. cit., "Politics and Government." pp 239-356.

Berle, Peter A.A. Does the Citizen Stand a Chance? Barrons, 1972. "Politics of a State Legislature: New York." A member of the New York State Assembly talks about the Legislative process and how necessary it is to have a concerned and educated voting public.

Butler, R. op. cit., "Pacification and Politics of Aging."
1. Agenda for Activism
2. National Policy on Aging - (Suggestions)

Hicks, "The Organized Elderly: A New Political Power." In New York Times, June 22, 1975.

Jacobs, B. Social Action: Expanding role of senior centers. Washington: National Council for Senior Citizens, 1974. Discusses how to implement social change within a senior citizen.

Metz, Joseph. The Politics of People-Power. Barrons Educational Series.

C. Community Service as a New Role

Providing service to others can help make the lives of older Americans more meaningful and challenging.

1. Programs

a. ACTION - Washington, D.C. 20525

Retired Senior Volunteer Program (RSVP)

Foster Grandparents Program

Service Corps of Retired Executives (SCORE)

Volunteers in Service

Senior Companion Program

b. Friendly Visitors issued by the New York State Department of Social Services describes programs in New York State.

c. Advisory Committees for Title III and Title VII Programs.

2. References

Arthur, J. Retire to ACTION: A guide to voluntary service. Abingdon Press, 1969. Written for the older American to describe opportunities for service in private and public agencies.

Atchley. op.cit., A theoretical description.

Butler. op. cit., Describes volunteer opportunities in government programs in an essay, "Toward a Service Society," pp 100-182.

Manney. op. cit., pp 84-85. Describes specific programs.

D. Leisure Activities

Creative use of leisure in interesting and involving activities can provide opportunities to explore and/or assume a variety of new and satisfying roles for the aged.

1. Programs

a. Senior Center movement - Materials describing senior citizen centers and how to organize them are available from the New York State Office for the Aging and from the National Council on Aging. NCOA also offers technical assistance to senior clubs and centers.

b. Title VII Nutrition Sites with Supporting Services - (Part of Older Americans Act) May imply roles in volunteering, political action and employment. Provides for a balanced meal served in congregate setting with following Supporting services -- Escort Nutrition education, Information and referral, Outreach, Recreation, Shopping assistance, transportation, health and welfare. The acronym. SENIORS suggests the need to live independently, to interact with others and to improve quality of their lives.

c. Recreation Programs for the Elderly in NYS. Chapter 1001 - Laws of NYS, provides State aid of $1.00 for every two persons 60 and over in the municipality.

2. References

Atchley, op. cit., pp 177-187, 261.

Butler, op. cit., p 169.

Kimmel, op. cit., pp 264-271.

Manney, op. cit., pp 82-85.

Havighurst, "Leisure and Life Styles." In Neugarten, op. cit., p 347.

Vickery, F. Creative programs for older adults; a leadership training guide. Association Press.

E. Employment Opportunities

1. Programs

a. Title IX of the Older Americans Act -- Public Law 93-29. "Community Services Employment for Older Americans."

b. CETA (Comprehensive Employment and Training Act - 1973). Title III funds target groups including elderly.

2. References

Butler, op.cit., pp 64-102. An excellent introduction to the "right to work." Points out discrimination in employment and late work capacities for older Americans.

Hunter and Woodrow, op. cit., pp 31-38.

Kimmel, op. cit., pp 241-261.

F. Continuing Education

The attitude that education is only for the young and primarily to get a good job needs radical revision if the aim in the United States is to improve the quality of life for all ages. More continuing education opportunities would be one way to stimulate new interests and new roles for the aged. As Zena Blau indicates: "The concept of continuing education would serve as an institutional link in which the individual could still perform useful social roles after retirement and widowhood."

1. Programs

a. Former NYS legislative action in 1974 allowed NYS universities and community colleges to admit senior citizens' tuition free to audit classes.

b. Programs in NYS offer courses for senior citizens at community colleges and high schools.

c. AARP/NRTA - Lifetime learning program. Write: Dean Hixson, Long Beach, CA. -- Senior Citizen Program, University of Kentucky offers courses leading to degree - Council on Aging, University of Kentucky, Lexington, Kentucky.

d. University Extension Class Program - Massachusetts State Department. Technical and craft courses. Massachusetts Commission on Aging, Boston, MASS.

G. The Elderly: Resource to Others

Sharon Curtain explains that being a grandchild taught her to be an adult. She remarks that in our culture, grandparents live separate lives where they cannot act as role models. Older people are the embodiment of a culture, the living proof that you will survive. Older people convey the past and provide prophetic wisdom of the future.

Dr. Eric Pfeiffer views the aging population as pioneers for they are encountering many of the problems we will all eventually face. They not only encounter these problems but are leading the way in working out solutions. In the study of successful adaptation to old age, the aging are pioneers.

The aging are finding new roles for themselves despite limited opportunities and changed circumstances. The rest of us must recognize the worth of these roles and regard the elderly as a resource and an example. Public policies should be directed toward finding options for older people that answer both their needs and the needs of the society.

1. References

Academy for Educational Development. Never Too Old to Learn. New York, 1974.

Atchley, op. cit., p 273-274.

Butler, op. cit., p 80-84, 387-389, 404-412.

Curtain, S. "Grandparents" New York Times Magazine, December 21, 1973.

Educational Program Ideas: Recreation for the Elderly. Albany, State Education Dept., 1968.

"Golden Oldies: Senior Citizens Go Back to School." Saturday Review of Education, February, 1974.

Knowles, Malcolm. Modern Practices of Adult Education: Andragogy vs. Pedagogy. 1970.

Manney, op. cit., p 82-84.

Pfeiffer, G. Quality of Life. A.M.A., 1975.

A Trainer's Guide to Andragogy. Washington, D.C.: Supt. of Documents.

UNIT SEVEN

EFFECTIVE INTERVENTION WITH THE AGED

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UNIT SEVEN

EFFECTIVE INTERVENTION WITH THE AGED

I. Introduction

This unit is designed to provide the learner with a general orientation to intervention skills when working with older persons on a one-to-one basis, as part of a family unit, or within a small group context. A second major purpose is to increase the practitioners' skill in promoting growth and to enhance the capacity of the older person to function and to cope in a variety of settings (family, small-group, institution). Of primary interest is the introduction of a helping process model applicable in dealing with interpersonal relationships and behavioral situations. Emphasis will be placed on the characteristics of the helping process model and the skills required of the practitioners.

The process of helping is a general interhuman experience. Human recognition, nurturance, affirmation, and encouragement and support are the essential ingredients in helping older persons achieve and maintain a sense of well-being, power, and control over their own lives. This is important in helping an older person to feel accepted and to accommodate to his or her tempo and pace. The ability to create an environment which supports and enhances the older person's belief in himself is necessary because some older persons respond to the devaluing culture messages about the aging and the aged. The kind and quality of the interactions, relationships, and activities are important to recognize if the gerontology practitioner is to help the older person. It is hoped that the beginning practitioner will gain a basic framework for understanding intervention skills, together with a recognition of the importance of knowledge, attitudes and values upon which the practitioner's helping behavior rests.

II. Textual Review of the Topic

A. State of the Art

The learner must be resourceful in developing an approach to helping older persons. No manual, book, or course can be developed to deal with all of the unique issues confronting older persons today. It is important to realize that the problems facing older Americans, and their consequent need for intervention, is that life situations are interdependent. The aging process and environmental influences are always inter-related.

UNIT SEVEN

Intervention requires an attitudinal and value perspective that is conducive to a positive helping relationship. Skill development especially communication skills are contingent on the values and attitudes one holds towards older persons, and the aging process. To be helpful, one also needs a perspective, or a model of practice from which to operate. This unit on intervention has presented the "Direct Service Helping Process Model" for such consideration. Hopefully, this model will prove useful for learner application, and further refinement. Only, as one uses the model, can one in turn, understand or improve upon it.

1. Overview

The practitioner will be exposed to:

a. Abraham Maslow's Theory on a hierarchy of human needs. All of us have needs and these needs take different forms and can be satisfied in different ways. According to Abraham Maslow, the sum of an individual's needs are arranged in a hierarchy with physical needs and the need for security at the base of the order. Physical needs (e.g., food, shelter, warmth) are those which must be satisfied in order to survive and maintain life. The need for security must be met if the organism is to function within its environment. For example, if the individual is not to be overcome by feelings of anxiety, there must be a measure of stability and consistency within the environment.

   Once the basic survival needs are satisfied and there is contact with society, other needs may press for fulfillment. These are: social, ego, and self-fulfillment needs. Social needs are recognized as individuals seek acceptance from others. Upon having social needs met, ego needs press for satisfaction and finally as the individual discovers answers to the uncertainties of his own unique identity then he can reach the fullest human potential possible. Thus, the practitioner's primary aim should be to help older persons to age successfully and enable older persons to reach their fullest human potential possible.

b. The values and knowledge base involved in working with older persons in relation to individual counseling, family members and small groups.

c. Record keeping.

B. Concepts, Literature, etc.

1. Definition of Responsive Communication - Direct Service Helping Process Model.*

a. Responsive communication with the older person means 1) to express interest in the older person's communication and its value. It is healthy, for example, for an older person to recall and retell earlier events in his life history; 2) to convey this interest in both a verbal/non-verbal manner, for example, boredom is readily apparent. Facial expressions are important. Build upon the older person's comments. Re-statements of the older person's feelings and experiences often indicate verbal interest. As we come to know the older person from his personal vantage point we also come to value and to like him.

2. Communication Skills

a. Acknowledges listening to others.

b. Gives clear statements of his own message.

c. Gives useful feedback in interpreting purposes, issues, etc.

d. Displays a sensitivity to timing of his own behavior.

1) Pertinent questions:

a) Does the worker verbalize the expectations for full and open communication?

b) Does the worker seem full and open in terms of his/her communication skills?

c) Is the worker a good listener in that she/he hears and responds to what the clients say?

d) Does the worker attempt to clarify statements that are not clear?

e) Does the worker ask questions or ask for opinions?

e. Is sensitive to non-verbal communication.

1) A person's tone of voice, posture, facial expression and gestures.

*The Direct Service Model, draws categories from Training Manual, 1968 for human service technicians working with older persons. The author is Louis Lowy and it is available from Boston Univ. Bookstores, 775 Commonwealth Ave., Boston, Massachusetts.

3. Data Collection

a. Descriptive statement concerning data collection. Sources of data are many. The primary one is the older person himself. What he is and how he feels and behaves should be given first consideration.

The significant people in the older person's life experience also contribute a secondary source of information. These include those with whom he has personal relationships, such as family and friends, and those within the more extended systems of which he is a part, such as church, social clubs, etc. Other sources include records, test reports, studies, and evaluations of various kinds. It is important that the helper continually assess what he is learning and observing. He looks for assets and liabilities within the individuals, the situations, and the relationships. He observes and weighs the important feelings and attitudes of the people involved; he contemplates the factors creating the present problem or concern and looks at how the person has handled such problems in the past. He looks at all of this in light of the resources that the older person possesses and what the community offers.

4. Data Analysis

a. Indicates a realistic assessment of individual, family, and small group strengths and limitations including:

1) The present problem as experienced by the individual, family and/or small group.

2) Summaries of physical, psychological, social, and environmental data.

3) Summary of diagnosis (the practitioner restating the problem in relation to the relevant data collected).

4) Tentative recommendations.

5. Problem Solving and Decision Making

a. Problem Solving Process

1) Identify the Problem

   a) Get to know and understand the older person. What is his background (cultural, religious, financial)?

   b) What is the problem as you see it, as the older person sees it?

   c) Determine the individual's weaknesses and strengths which will either delay or aid in solving the problem.

   d) How had the older adult handled his problems before? What is his style regarding solution or problems? Does he prefer to do it for himself, have others help, etc?

2) Determine what should be done.

   a) What resources are available to help?

   b) Make a plan of action based on knowledge of the problem or problems.

   c) Is the individual in agreement with your goals for him?

   d) Does the older person have the capacity to achieve this goal?

   e) Is the plan realistically possible (from the point of view of available resources, worker's time,)?

3) Implement Plan

   a) Form a positive relationship. The older person's ability to accept help and to improve is dependent on the strengths of his relationship with the helper. It takes time for the older person to accept a new relationship.

   b) Recognize and understand the older adult's feelings regarding the worker. Does he think of the worker as son, daughter, grandchild, parent? Differences in age and cultural background will provide certain feelings in both client and worker.

4) Stimulate the client's motivation to accept help.

   a) Recognize the fact that older people can change.

   b) Utilize his strengths to help himself.

c) Help him to do something which gives him a sense of achievement and success.

d) Help the older person to have a sense of future.

e) Help the older person to feel useful and worthwhile.

f) Help him to have a sense of dignity.

g) Exchange should have a give and take quality.

h) Respect the older person's feelings of privacy, confidentiality and comfort.

5) Make all referrals in accordance with the individual's need, agency policy, and community resources.

a) Determine the individual's need and the appropriate sources to fill the need.

b) The individual must be helped to see the need for the referral. It cannot be made against the person's wishes.

c) The worker is the liaison between the client and the referral or referring agency and should follow through on both referrals made and those accepted.

d) Permission (often in writing) from the individual to give information to the referral source is necessary. In the same way, on a referral received follow-up information to the agency should also have the client's permission.

e) Confidentiality must be respected.

6) Techniques employed to bring about a certain result depend on the basic personality of the individual being helped and the particular goals set.

a) Reaching out is important in engaging those older individuals who can't expect or accept their need for help, those who are too depressed and feel hopeless, and those who don't know the available sources of help.

i) Be visible - consistent.

ii) Be flexible.

iii) Be creative on your approach.

iv) Express connection about what you have to offer.

v) Show encouragement.

vi) Stimulate individual's own interests.

vii) Don't discuss individual's sore spots, (religion, sex, politics, money).

viii) Pursue your client. Visit again even if the client has shown no interest. It takes time for trust to develop and acceptance of help is based on trust of the one giving help.

b) Self-help is the best technique for those individuals who feel strongly that they must help themselves, that they are their own decision makers. The individual has the right to determine his own choices, actions and the possible resulting outcome.

i) Expose alternatives.

ii) Give suggestions in loose manner.

iii) Don't take over.

iv) Allow the older adult a feeling of independence.

v) Find out how individual has solved problems before and help him to utilize similar methods.

c) Professional responsibility. The worker is responsible to the agency and should keep records and reports to better help the client and protect the agency.

i) Keep records on activities and responses of client and self.

ii) Write reports which are clear and to the point.

iii) Telephone in a professional manner respecting confidentiality, yet giving well thought out information which will benefit the client.

6. Evaluation

a. The importance of evaluation in working with older persons.

1) Evaluating what the worker is doing and what the client needs should take place periodically. Changes occur, resistances build up, and the worker's perceptions can become blurred. Supervision is necessary for basic learning. It also helps to develop an ability to evaluate one's own work.

2) Re-assessment. The needs of clients change; our attitudes toward clients change; and at different times resources become available as source. Assessment and reassessment of a worker's ability to help, his values, his performance and a client's needs and process are by necessity an ongoing process.

7. Forming Helping Relationships

a. The concept of relationship and its component parts.

1) Acceptance:

a) The basis of any relationship is acceptance of the individual's right to existence, importance and value. Indifference or lack of concern can completely inhibit the development of any meaningful interchange and can be more destructive than actual dislike.

b) Acceptance involves recognition of the uniqueness of the individual as a person who possesses the need and right to participate in making decisions about matters relating to his own welfare. The extent to which a person is able to exercise this need varies among individuals but the need is there.

c) Acceptance involves expectation. We not only accept people for what they are, we accept them for what they are capable of being, and this reality-based expectation assumes great significance in a helping relationship.

2) Dynamic

a) All must participate actively in the process. A one-sided reaching out effort does not constitute a relationship. The extent of this capacity may and does vary in degree among individuals.

3) A relationship is always changing. Older persons change and grow, and new feelings and attitudes are always being fed into the process.

4) Purposeful and Time Limited

a) A relationship is purposeful and goal directed. If this were not the case then there would be no need for a helping relationship. When the purpose is served and the goal achieved, the relationship is terminated. Prolonged relationships become sterile and meaningless. The worker's role demands that he teach his client how to use help how to use himself, and where to turn when future assistance is needed.

8. Functional and Behavioral Roles

a. Practitioners should be knowledgeable about and should have skill in using these roles to relate more directly to individuals, family, and/or small group's tasks, goals, functions.

1) Initiator - Suggests new ideas or a changed way of looking at a problem or goal, and proposes new ways of achieving goals.

2) Information Seeker - Asks for relevant facts or authoritative information.

3) Information Giver - Provides relevant facts, authoritative information or relates personal experiences pertinently to the task at hand.

4) Opinion Giver - States pertinent belief or opinion about something the group is considering.

5) Clarifier - Probes for meaning and understanding, reinstating something the group is considering.

6) Elaborator - Builds on a previous comment, enlarging on it, giving examples.

7) Synthesizer - Shows or clarifies the relationship among various ideas, and tries to pull ideas and suggestions together.

8) Orienter - Defines progress of the discussions in terms of the individual's, family's and/or small group's goals, raising questions about the direction the discussion is taking.

9) Tester - Checks to see if the individual, family, and/or small group is ready to make a decision or take some action.

III. Objectives

The purpose of this unit is:

A. To increase helping skill in relating effectively to older persons and/or families.

UNIT SEVEN

1. Cognitive Objectives

The practitioner sould be able to:

a. Develop knowledge of his own problem, abilities, limitations (self-awareness).

b. Identify his own learning needs.

c. Recognize differences between personal and professional difficulties.

d. Understand the sympotomatic and purposive nature of behavior.

e. Identify own and older person's prevalent, recurrent behavioral patterns.

f. Identify the environmental factors which support or inhibit the present behavioral pattern.

g. Help the older person evaluate his present mode of interaction in terms of his satisfaction or dissatisfaction with the results of his interaction with others.

2. Affective objectives

a. Utilize one's self in a conscious, disciplined manner.

b. Identify own emotional reaction to older persons.

c. Bring an acceptance of own limitations.

d. Bring a positive concern for new learning and change.

e. Accept differences and limitations (non-judgmental) of the older individual.

f. Respect older individual's rights and choices (within limits).

3. Behavioral objectives

a. Recognize the emotion being expressed verbally and nonverbally by the older person.

b. Respond by stating tentatively the feeling and content being expressed by the older person.

c. Communicate verbally and non-verbally a belief in the older person's ability to grow and increase his effectiveness as a person.

d. Identify own and older person's prevalent, recurrent behavioral patterns.

e. Assess the effectiveness of the older person's behavioral patterns and meeting basic human needs.

f. Assist older persons and/or families to recognize their pattern of behavior and its consequences.

g. Help the individual and/or family examine the process that resulted in more effective living.

h. Gain new appreciation of one's past and present through the helping relationship.

i. Help the older person evaluate his present mode of interaction in terms of his satisfaction or dissatisfaction with the results of his interaction with others.

j. Support the older person in his struggle to adapt to changing conditions.

B. To increase ability to utilize the problem solving process with older persons.

1. Cognitive Objectives

a. Assess how the older person and/or family sees the present difficulty.

b. Differentiate between the perceptions of the problem as the helper, the institution or referring agency sees it.

c. Record the significant factors about the older person and his situation.

d. Anticipate future needs or events such as termination and impact on older person's development.

2. Behavioral Objectives

a. Help the older person utilize his potential for reality-based problem solving within the framework of his traditions and culture.

b. Assess how the older person and/or family see the present difficulty.

c. Help the older person to define or clarify the problem as he perceives it and its relevant physical, psychological, social or economic implications.

d. Assist the older person, small group, and/or family system analyze the total information available regarding the problem and formulate a plan of action.

e. Support the older person and/or family in carrying out the plan of action.

f. Record significant factors in the helping process and their impact on older person's development.

C. Recognize the developmental and situational crises that are relevant to the older person.

UNIT SEVEN

1. Cognitive Objectives

   a. Assess the prior and present coping mechanisms of the older person in relation to crisis.

2. Behavioral Objectives

   a. Focus on the older person and his emotionally meaningful milieu during crisis.

   b. Acknowledge the older person's potential to cope with the crisis.

   c. Assess the prior and present coping mechanisms of the older person in relation to crisis.

   d. Help the older person confront the reality situation of the crisis in manageable doses.

   e. Help the older person recognize and attach his physical symptoms to the present crisis in his life.

   f. Facilitate the older person's acceptance of help and support at crisis points in his life.

   g. Take appropriate action on behalf of the older person at times of acute crisis.

D. To increase knowledge of community resources to facilitate referrals and to interpret services in order to help older persons effectively meet their needs.

The learner should be able to:

1. Cognitive Objectives

   a. Assess older person's motivation and desire for help.

   b. To utilize knowledge about community agencies, their purpose, function and service.

2. Behavioral Objectives

   a. Interpret and clarify the agency, its functions and services to the older person and the family.

   b. Interpret the older person or family's situation to the agency.

   c. Facilitate the referral and follow-up of the older person to existing agencies.

   d. Support the older person or family through the referral process.

IV. Topic Outline

A. Introduction and overview of the unit on direct service work with older persons.

1. Issues

2. General orientation

B. Direct service helping process model

1. Responsive communication

a. Verbal and non-verbal communication skills

2. Data collection

a. The older person

b. Significant people

c. Significant events

3. Data analysis

4. Problem solving and decision making

a. Problem identification

b. Formation of helping plan

c. Implementation of plan

1) Formation of positive relationships

2) Recognition of older adult's feelings towards the worker

3) Stimulate client's motivation to accept help

4) Referrals and procedures

5. Techniques

a. Reaching out

b. Self-help

c. Professional responsibility

d. Evaluation

6. Forming helping relationships

a. "Acceptance" as a concept

b. Dynamic nature of relationships

c. Goal directed relationships

7. Roles which relate to the helping relationship
   a. Initiator
   b. Information seeker
   c. Information giver
   d. Opinion giver
   e. Clarifier
   f. Elaborator
   g. Synthesizer
   h. Orienter
   i. Tester

V. Instructional Strategies

A. Teaching Aids and Resources

1. Field trips

A field trip, when carefully planned around a specific teaching objective, with adequate preparation, directed observation and a well-coordinated discussion afterwards, is for many students a dynamic learning experience and one likely to elicit active response from those who participate in it.

2. Rumor Clinic

Taking part in or observing a rumor clinic to learn how people tend to see what they expect to see, and how those pre-conceptions distort what actually takes place, can stimulate and reinforce the awareness necessary in work with older persons. An excellent three-frame black and white filmstrip is available ($1.00 - Anti-Defamation League B'Nai B'Rith, 315 Lexington Ave., New York, N.Y. 10016) and helps to make persons aware of prejudices and how rumors start to spread. It can be used as a springboard for discussing prejudments and the importance as well as the difficulty of accurate observation.

3. Plays

Dramatic presentations are a medium for learning about aging and for considering the needs and problems of older persons. For example, the play, "A Choice to Make," is about an older woman who finds the adjustment to widowhood, loss of friends, and her only son's threatened move to a distant city overwhelming. Through a friend and an understanding counselor, she is able to achieve a new equilibrium. (Production packets

of six copies are available for $12. from "Plays for Living", Family Service Association of America, 44 East 23rd Street, New York, N.Y. 10010). "Ever Since April" depicts what happened to a man and his family upon his retirement. (Also available from "Plays for Living"). "The Room Upstairs" portrays the tensions which may arise in a family when an elderly parent comes to live in the home. (Human Relations Aids, 104 East 25th St., New York, N.Y. 10010).

4. Role Playing

Role playing is the spontaneous acting out of roles in the context of human relations situations. The situations should be clearly defined, simple, and the roles specified. The more spontaneous the action, the more successful the role play is likely to be. The question is asked first, what roles are involved? Roles are then taken voluntarily, by various group members and a few minutes allowed for the role players to develop the main lines along which they will proceed. The role play is then acted out, usually for as little as five minutes and mostly for not more than twelve or fifteen minutes. Sometimes several other members re-enact the role play as they see it, thus providing a basis for comparative discussion. The role play is then analyzed, and if it has been video taped, that is viewed. Occasionally the leader may ask the group if they would like to replay the roles in light of the discussions. This is one way of demonstrating gains in insight and skill. The class may be asked at the end of the course, if they would like to listen back to a tape of a role play made weeks or months before. This is one way of evaluating changes that have taken place in knowledge, attitudes and skills.

Role playing is an approach which might utilize professional consultation. Roles should be selected that are not threatening to the participants themselves. For example, a woman who has just lost her husband should not be expected to portray a woman who has just lost her husband. Emphasis should not be given to situations that are capable of producing stress. The same cautionary note should relate to all participatory-learning experiences in this section.

5. Recordings (Narrative Process)

If available, written logs or recordings of visits or interactions by the worker in dealing with older persons can be discussed in class. Goals for intervention skills, attitudes and general effectiveness of the helping person may be evaluated with those means.

UNIT SEVEN

6. Films

a. Old Age - The Wasted Years (2 reels)

60 mins. $9.15

In this study of the aged, the individual who has retired and the worker who loses his job due to advancing years are seen in terms of limited social opportunities that await them and the living situations available to them. (HET - Indiana University).

b. Place to Live

30 mins. $10.00

Shows how age of a father creates emotional, social, financial problems for daughter. The importance of shelter care is also stressed.

c. Rights of Age

28 mins. $85.00

Protective services available for the aging are dramatized in an in-depth study of an elderly widow. Shows coordination approach by professionals.

VI. Annotated Bibliography

Brill, Naomi - Working with People: The Helping Process

J.B. Lippincott Company, New York, N.Y., 1973.

This is a very helpful paperback edition for people who work with other people. It is not geared just for social gerontologists, but the values and processes found in this book are certainly helpful for those in this field of service. The book is very readable and deals with all the important components of the helping process. It is both theoretical and pratical. The book is useable for beginners and stimulating for those in professional service as well.

Twente, Esther - Never Too Old

Jossey-Boss, Inc., San Francisco, 1970

Esther Twente is a person with many years of experience in the field of aging. She uses this experience in establishing a perspective for working with the aged. The book is geared for those persons who serve older persons in smaller communities. The emphasis is on the needs of the well aged

and the important considerations in working with such individuals. Attention is given to the importance of group and individual activities for older persons and the service agencies that seek to serve them. The book presents a perspective on intervention with the "well elderly" and helpful case studies to illustrate the major points of the book.

Field, Minna Aging with Honor and Dignity

Charles Thomas Publisher, Springfield, Illinois, 1969.

A helpful book, especially for those who have concerns around "individualized" approaches to serving the elderly. The book is especially useful, if one wishes a short, concise comprehensive perspective of the issues confronting older persons. The limitations are that the topics are short and abbreviated. Chapters on inter-generational relationships and family matters are insightful.

Butler, Robert Why Survive?, Being Old in America

Harper & Row, Publishers, New York, N.Y., 1975

Chapter 6, "No Time to Wait"

This chapter presents a description and critique of social services for older persons. Other chapters deal with the health, mental health, housing, work and economic needs of older people. This portrayal is in the context of a society that is blatantly against older persons. As an outstanding clinician and statesman of the rights of the elderly, Dr. Butler concludes with social policy directives in response to these needs. An excellent book for those who want a more in-depth perspective on the issues confronting the elderly and implications for social interventions.

Foundations of Practical Gerontology (2nd Edition)

Rosamonde Boyd & Charles Oakes, University of South Carolina Press, 1973.

Part III, "Psychological and Psychiatric Aspects of Aging"

The author, Adriaan Verwoerdt, offers some practical suggestions for intervention based on personality differences and senescence. The importance of life review is stressed. Distinction is made between depression and senility and appropriate means of treatment.

Chapter 13 is an effective chapter on volunteerism and the management and administrative features of such efforts, and their relationship to mental health.

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Chapter 15 gets at recreational programs for the elderly. It stresses leadership needs and program suggestions.

Normal Aging, edited by Erdman Palmore,

Duke University Press, Durban, S.C., 1970

Chapter 3 on mental illness has some effective material that is useful for intervention purposes. Pages 90-97 offer direction for the treatment of depressed persons.

Chapter 9, "Activities and Satisfaction" and the influence of race and socioeconomic status upon activities offers useful material in determining the activity need of different populations of older persons.

Aging and Society (Volume Three, 1973). A sociology of age stratification by Matilda Riley. Marilyn Johnson, and Anne Foner.

Chapter 9 - "Friendship" by Beth Hess

Good on what friendship does and doesn't do for older persons. Helpful in showing the professional what the boundaries and concerns are in this regard. pp 357-390.

Chapter 11 - "The Life Course of Individuals" by John Clausen. pp 457.

The chapter describes the subject of development within the life span.

Aging and Society (Volume Two) Aging and the professions by Matilda Riley and Marilyn Johnson

Chapter 2 - "Aging and the Field of Social Work" by Robert Mains. pp 18-54.

An excellent overview of challenges confronting social work as it relates to the health, mental health, economic and social issues of older persons. New information on aging is utilized in relationship to new forms of professional and institutional intervention. Implications for social policy are stressed.

Other chapters deal with the professions of medicine, nursing, public health, financial management, architecture, law, industry, education and mass communication.

VII. Bibliography

Council on Social Work Education. Teacher's source book on aging. New York Council on Social Work Education (1964) 345 East 46th St., New York, N.Y. 10017.

Knowles, Malcom and Hulda. Introduction to Group Dynamics, Revised Edition, New York, Association Press, 1972. Chapter 3 - "Understanding Group Behavior."

Konopka, Gisela. Social Group Work: A Helping Process - 2nd Edition, Prentice-Hall, Inc., Englewood Cliffs, N.J.

Chapter 5 -"The Value Base of Social Group Work."

Chapter 9 - "The Social Group Worker's Role in Various Fields of Practice, pp. 189-192. Service to the Aging.

Maslow, Abraham, H. Motivation and Personality, 2nd Edition, New York, Harper and Row, 1970. Chapter 5 - The Role of Basic Need Gratification in Psychological Theory.

Syracuse, N.Y. Program Resources Regional Education Center, Program Resource Catalog.

A catalog of programs, resources, and services contributed by Central New York Developmental Center and Psychiatric Center, and the Regional Education Center of Syracuse. Edited by Thelma J. Fitch, Syracuse Regional Education Center, 1975.

Vickery, Florence E. (Social Work with the Aged) Creative programming for older adults: a leadership training guide (by) Florence E. Vickery, New York Association Press (1972).

Particularly geared to those practitioners interested in multi-service Senior Centers and Social Clubs for older adults.

Wilson, Gertrude and Gladys Ryland, Social Group Work Practice, Houghton Mifflin Co., The Riverside Press, Cambridge, Mass., 1949, pp. 76-80. Writing Reports and Records

VIII. Additional Resources

Where to go for additional help:

1. American Association of Retired Persons
   1909 K Street, N.W.
   Washington, D.C. 20049

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2. The Gerontological Society
One Dupont Circle
Washington, D.C. 20036

This professional society has an annual meeting and an international meeting every three years. It is made up of four components - Biological Sciences, Clinical Medicine, Psychological and Social Services and Social Research, Planning and Practice.

3. National Association of Social Workers
2 Park Avenue
New York, N.Y. 10016

4. National Council on the Aging
1828 L Street, N.W.
Suite 504
Washington, D.C. 20036
(Research and services regarding the elderly)

5. National Council of Senior Citizens
1511 K Street, N.W.
Suite 202
Washington, D.C. 20005
(Represents and lobbies for needs of the elderly)

6. Retired Professionals Action Group
Suite 711
200 P Street, N.W.
Washington, D.C.
(This group investigates reports and class action cases)

7. Urban Elderly Coalition
   c/o Office of Aging of New York City
   250 Broadway
   New York, N.Y.
   (Effort of municipal authorities to obtain fund for urban elderly poor)

8. Action
   Washington, D.C. 20525
   (Many federal programs for the elderly)

9. Administration on Aging
   U.S. Department of Health, Education and Welfare
   Washington, D.C. 20201

UNIT EIGHT

PUBLIC POLICY AND THE AGED:
PAST, PRESENT AND FUTURE

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UNIT EIGHT

PUBLIC POLICY AND THE AGED

I. Introduction and Topic Overview

Although there are numerous definitions of Public Policy, perhaps the most succinct and useful are the following offered by Yehezekel Dror and Ira Sharkansky respectively:

> "Public policymaking is a very complex dynamic process whose various components make different contributions to it. It decides major guidelines for action directed at the future, mainly by governmental organizations. These guidelines (policies) formally aim at achieving what is in the public interest by the best possible means."

> "Policy outcomes express the value allocations of a society, and these allocations are the chief output of the society's political system."

With these definitions in mind and considering the fact that every area of gerontology can be considred within the framework of public policy, the content of this unit is structured to show the provisions and effects of existing policies as a basis for understanding the prescriptions for future policy developments. For a more advanced or sophisticated analysis of public policy or, more appropriately, for a course solely devoted to policy analysis, the descriptive and prescriptive elements can be followed by an explanation of how to achieve the prescription. More succinctly, a framework for the analysis of public policy should include the discussion of what is, what ought to be, and how to close the gap between the two.

The approach to this review of public policy and the aging is based on the opinion that present social policies for serving our older population are underdeveloped, do not meet the needs of this population, and are in need of improvement.

WHAT IS

For an examination of existing public policy regarding older persons, there should be a review of the Social Security Act of 1935 and its subsequent amendments, the Older American Acts of 1965 and its amendments, and a review of appropriate Federal Acts which are referred to in other sections of this handbook. The Social Security Act and the Older American Act have been the major statements of public policy to date.

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It is not surprising to identify only two major public policies on aging now operating in our nation. Policy on aging is a new phenomenon on the local, national and international levels. Only in the past forty years has there been a national social policy on aging in the United States, putting this country some thirty-five years behind similar developments in most of Western Europe. Most of the recent emphasis is due to demographic facts showing that aging has become an important issue.

Social Security, our first major national social policy was not aimed at developing a comprehensive income protection and security program. Rather, it was considered as a supplement to savings and pensions. Similarly, the Medicare and Medicaid amendments of 1965, while beginning to meet the health needs of older persons, are also faced with shortcomings, and thus cannot be considered a comprehensive health program for older Americans. There are limits to coverage and gaps in services. These limits need to be known by those who provide service to the aging.

At the state level, responsibilities to serve the aging began to emerge in the 1960's. Although New York and New Jersey began unfunded efforts in the 1940's, it was only in 1961, after the White House Conference on the Aging that each state received small amounts of funding to examine their potential roles in serving the aged in their states. Up to that time, only local efforts had been initiated in the interest of the aging. In 1965, the Older Americans Act initiated a variety of demonstration projects at the local level. The 1973 amendments significantly focused on state and federal relationships, thus forming a vertical structure for decisions and service delivery.

In addition to the major pieces of legislation pertaining to aging, there recently have been several federal acts which impact on the aging or make special provisions for older persons. This is especially true with recent housing and health legislation.

An analysis of a combination of these acts will identify the present level of services available for older persons, especially when examined in the light of available funding.

WHAT OUGHT TO BE

There are several ways to explore a more ideal state for public policy. One way is review the outcome and statements of major goal setting forums, such as the White House Conference on Aging in 1961 and 1971. Each of these convocations produced documents outlining major goals for the aging. It is interesting to note the similarities of the documents prepared a

decade apart. Tracing federal action after these conferences also provides meaningful insights into the politics of aging.

Another means of defining goal statements for policy development is to examine the purposes of those special interest groups representing segments of the older population. These groups include the National Council on Aging, the National Council of Senior Citizens, American Association of Retired Persons, National Retired Teachers Association, the Gray Panthers, and a variety of local advocate groups. An examination of the agencies of these organizations should provide further insight into "what ought to be."

There are several other resources which can contribute to this review of the publicly structured surrogates or advocates of the poor. The Senate Select Committee on Aging and the recently formed House of Representatives Committee on Aging can provide information on what can be designed to aid the aging. Local and state structures, such as state offices on aging or local area agencies on aging, are trying to influence public policy, and thereby provide other views of what ought to be. Special bodies such as the National Institute on Aging and the National Institutes of Mental Health are also involved in this area. Finally, professionally oriented groups such as the American Geriatric Society and the Gerontological Society hold public positions which can be interpreted as statements of "what ought to be."

HOW TO CLOSE THE GAP

Getting from what is to what ought to be is a concern of those who provide services to older persons and those effected by those services. Some portion of this unit should discuss political influence in its various forms, suggesting possible future developments. Work in this area is beyond the scope of this course; however, insights into these processes may be gleaned by examining how the various private interest groups operate to achieve their goals.

II. Suggested Instructional Objectives

A. Affective Objectives

Students studying this unit should begin to develop:

1. An awareness that present public policy in the United States is not yet developed to meet the needs of the aging.
2. A conviction that part of the responsibility of those serving older persons is to take an interest and role in the further development of public policy affecting older persons.

3. An awareness of how one's own job performance, if working in programs serving the aging, is an important part of the policy systems that shape the humanity of serv. e.
4. A belief that all persons, especially older Americans, ought to have important roles in shaping public policy.

B. Cognitive Objectives

After completing this unit, students should be able to:

1. Identify and describe the developments and contents of the major United States public policies on the aging.
2. Describe the deficiencies of these public policies in meeting the needs of older Americans.
3. Describe specific proposals for the improvement of public policies toward the aging.
4. Identify the major structures of government that establish public policy on the aging.
5. Identify and describe the contribution of major private, nongovernmental groups interested in improving public policy on the aging.
6. Identify the major sources of information describing existing and proposed public policy on the aging.
7. Cite examples of how public policy not specifically directed to older persons may affect their lives.

(Note: These are suggested objectives, and there may be others specific to a given instructional situation. This unit should carefully be planned to stress those objectives which seem most important.)

III. Outline of Specific Topics and Sub-Topics

A. Public Policy Defined

1. Definitions
2. Policy Structures
   a. Executive, Legislative, Judicial, Administrative
   b. Federal, State, Local

B. United States Policy on Aging - What Is:

1. History, Philosophy and Development - Federal
   a. Social Security Act of 1935 and Amendments
   b. White House Conferences on Aging, 1961 and 1971

c. Older Americans Act of 1965 and Amendments

d. Other Federal Acts (see other syllabus section on Environment, Health, Economics, etc.)

2. Developments at the State and Local Levels

3. Judicial actions

C. United States Policy on Aging - What Ought to Be:

1. Comparison of existing policies and needs of older persons.

a. Identification of policy gaps

2. Activities to improve policy

a. Governmental

1) Federal Legislature (Senate Select Committee, House of Representatives Committee)

2) State and Local Activities (Governmental, AAA, State Offices on Aging)

3) Special Bodies (NIA, NIMH, NICHD)

b. Special Interest Groups (NCOA, NCSC, SCAA, AARP_NRTA, Gray Panthers, Local Citizens Groups)

D. Impact of Other Policy Areas on the Aging (i.e., Energy, Economics, Environment, etc.)

IV. Instructional Methods

These are suggested for use based on time allocated to the subject, experience of the student, and availability of resources. If time permits, more attention to this area is suggested in order that local experts be utilized to the maximum. In addition, a simulation would be a valuable experience for understanding community dynamics in planning policy.

A. Public Policy Defined

1. Lecture and readings

2. Discussions with students about what they are able to surmise about public policy for the aging from their observations of the life style provided for the aging by society and the issues covered in previous units of this course.

3. For more advanced students, a short paper on what, in their estimation, public policy in aging consists of might be appropriate.

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B. United States Policy on Aging - What Is:

1. Lecture and readings
2. Use of Film: "Never Trust Anyone Under 60" available on free loan from:

   General Services
   National Archives and Records
   National Audiovisual Center
   Washington, D.C. 20409

   and/or slides available from the New York State Office for the Aging or the White House Conference on Aging - 1971.
3. Speakers from local Area Agency on Aging, Social Security Administration or Medicaid Office. Ask these speakers to address the topic of public policy; i.e., what major legislative acts affect their operations and how they perceive their role in establishing, implementing and changing policy in their area of concern. Ask students to prepare questions.
4. Written excercise. For further credit, a student might be encouraged to read legislation and/or regulations of an act directly affecting the aging (i.e., Older Americans Act of 1965 as amended) and write a precis of its major points.

C. United States Policy on Aging - What Ought to Be:

1. Lecture, readings, group discussion. Discussions should explore the area of how one might influence public policy and what groups (local, state, national) are working toward change.
2. Guest speaker from local senior citizen advocacy groups, if available.
3. Student projects - either individual or in small groups. Students might (a) read one or two government publications listed on the secondary bibliography and present a report; (b) collect and analyze reports and literature from one of the aging organizations listed on the bibliography.

D. Impact of Other policy Areas on Older Persons

1. Lecture, readings
2. Group discussion. Discussion should center around tie-ins with other units of the course; examples of inadequate policy in areas such as income, housing, transportation, and health.

3. Students might devise a comprehensive system of service delivery to meet the needs of the elderly. This could be an abstract exercise given the freedom of having no monetary constraints, etc. It could also include a discussion about what constraints exist in establishing such a program, and how they might be overcome.

V. Evaluation Strategies

As with instructional methods, evaluation should be tempered by the amount of time available, the experience level of the student, and the choice of the instructor. With this in mind, some suggestions for evaluation of this unit follows:

A. Testing

Objective Tests, particularly in the form of essay questions derived from the cognitive objectives of this unit, would provide an indication of student achievement of those objectives. These tests could be evaluated by the instructor for a grade or by the students as a means of pointing out areas for further study.

B. Report Writing

During the unit, students might be responsible for developing a short paper on a particular aspect of public policy. These reports could be shared with, and evaluated by the group as a whole or may be submitted to the instructor for a grade. More specific suggestions are given under "Instructional Methods."

C. Student Participation

A student might be evaluated on the extent to which he participates in class discussion and displays a grasp of the content areas.

D. Subject Evaluation

This type of evaluation could take several forms:

1. Student could be asked to write a synopsis both of what he has learned and what he has contributed to the class as a whole and be graded according to this synopsis.
2. Student could be asked to write what changes have occurred through this learning experience in relation to his/her attitudes about the aging person in today's society.
3. Student could be asked to write a paper on the topic of "What ought to be public policy in the United States with regard to Aging."

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VI. Bibliography

United States Public Policy on Aging - What Is.

Busse, E. W. and Pfeiffer, E. Behavior and Adaptation in Late Life. Little, Brown and Co., Boston, 1969. Chapter 18. J. Spengler: "The Aged and Public Policy."

Cohen, Wilbur J. and Friedman, Milton Social Security: Universal or Selective. Washington, D.C., American Enterprise Institute for Public Policy Research, 1972.

Manney, James D. Aging in American Society. The Institute of Gerontology, University of Michigan - Wayne State University, Ann Arbor, Michigan, 1975. Part III "Policies and Programs," pp 123-171.

"Political Consequences of Aging." The Annals of the American Academy of Political and Social Science. Vol.415. September 1974.

-"The Role of the Federal Government in the Provision of Social Services to Older Persons" by Byron D. Gold pp 55-69.

-"Old Age Associations in National Politics" by Henry J. Platt pp 106-119.

-"Age Groups in American Society and the Rise of the Young-Old" by Bernice L. Neugarten pp 197-198.

-"Aging and the Future of American Politics" by Robert H. Binstock pp 199-212.

Riley, Matilda White (Ed.) et al. Aging and Society. Vol. I: "An Inventory of Research Findings." New York: Russell Sage Foundation, 1969. Chapter 19, "Political Roles" pp 463-481.

Riley, Matilda White (Ed.) et al. Aging and Society, Vol. II "Aging and the Professions." New York: Russell Sage Foundation, 1969. Introduction pp 1-18. Other chapters as indicated by professional attachment; i.e., social work, medicine, etc.

Annotation: The above references provide an overview of what policy currently exists in the United States. The Busse chapter gives an outline of historical and developmental stages of social policy, while the Manney references explores policy in relation to issues as housing, income, and transportation.

United States Public Policy on Aging - What Ought to Be

Toward a National Policy on Aging Proceedings of the 1971 White House Conference on Aging, November 28-December 2, 1971. (Vol. I and II). Washington, D.C. United States Government Printing Office, 1972.

Vol. I Part 1 "Background, Concepts, Planning" pp 3-14.
Part 2 "Action at Community and State Levels" pp 21-28.
Part 5 "A Delegate's View of the Conference" pp 147-149.

Vol. II Introduction V

Part I Section Recommendation: "Government and Nongovernment Organization" pp 79-85.

(Other sections on various issues and special concerns and sessions)

Post-White House Conference on Aging Reports, 1973 (Joint Committee Print, prepared by the Subcommittee on Aging of the Committee on Labor and Public Welfare and the Special Committee on Aging). September, 1973. (pp 159-182 - Special Message on Aging - Nixon. pp 8-19 - Administration Report on Policy 8-18. pp 21-159 - Summary of Conference Recommendations and Responsibility on Issues: income, housing, nursing homes, etc.)

Developments and Trends in State Programs and Services for the Elderly. Committee Print, November 1974 pp 5-40.

Developments in Aging: 1973 and January-March 1974. A Report May 1974. (The New S.A.A. pp 103-110. Also wealth of information on various areas of case study: income, nursing homes, housing, health, transportation, etc.)

Jackson, Hobart C. "National Goals and Priorities in the Social Welfare of the Aging." The Gerontologist, Vol. II, No. 1. Spring 1971, Part I.

Annotation: The above references outline the current policy recommendations and trends toward change in the field of aging. The Post-White House Conference Reports are perhaps the most important as they enumerate both the recommendations of the White House Conference and the Administration's response.

UNIT EIGHT

For further exploration into the realm of "What Policy Ought to Be," the following organizations can be contacted:

The Senate Special Committee on Aging G-233 Senate Office Building Washington, D.C. 20510 Phone: (202) 225-5364 William Oriol - Staff Director	This committee acts in an advisory capacity to the Senate. Publishes a comprehensive list of hearings, studies and working papers it has conducted and sponsored in the past year.
The National Council on the Aging 1828 L Street, N.W. Washington, D.C. 20036	NCOA is a volunteer agency that provides leadership services for organizations and individuals concerned with aid to the aging.
Gerontological Society One Dupont Circle Washington, D.C. 20036	A professional organization comprised of those interested in improving the well-being of older people. Publishes the Journal of Gerontology and The Gerontologist.
Administration on Aging Department of Health, Education and Welfare 330 Independence Avenue, S.W. Washington, D.C. 20201	Administering grant programs to states designed to stimulate the development of public and private services and opportunities for older people at State and Local levels.
American Association of Retired Persons and National Retired Teachers Association (AARP-NRTA) 1909 K Street, N.W. Washington, D.C. 20019	AARP-has a membership of 9 million, their aim is to improve every aspect of living for older people. Publishes NRTA Journal and Dynamic Maturity. NRTA has a membership of 500,000.
National Center for the Black Aged 725 DeSalle Street Suite 402 Washington, D.C. 20009	Collects, evaluates and disseminates information on the elderly Black community.

Gray Panthers 3700 Chestnut Street Philadelphia, Pennsylvania 19104	A group of young and old people struggling to build a new power base in our society for the elderly. The issues they work with include upgrading nursing homes and establishing National Health Insurance.

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